# STATE TITLE V BLOCK GRANT NARRATIVE
# STATE: DC
# APPLICATION YEAR: 2006

# I. GENERAL REQUIREMENTS

## A. LETTER OF TRANSMITTAL

The Letter of Transmittal is to be provided as an attachment to this section.

## B. FACE SHEET

A hard copy of the Face Sheet (from Form SF424) is to be sent directly to the Maternal and Child Health Bureau.

## C. ASSURANCES AND CERTIFICATIONS

These documents are available upon request to Marilyn Seabrooks Myrdal 202 442 9333.

## D. TABLE OF CONTENTS

This report follows the outline of the Table of Contents provided in the "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; published June, 2003; expires May 31, 2006.

## E. PUBLIC INPUT

Hard copies of the application submitted July 15, 2004 were distributed to the central and branch libraries in August 2004, as will be done with the current application. In conjunction with the 5-year needs assessment, summaries of the comprehensive data compilation were presented to participants in 4 focus groups convened during the summer of 2005. Teens comprised 1 focus group and a parents' advisory group another. The other 2 groups included both representatives from community organizations and Administration staff. A technical assistance contractor funded through the Maternal and Child Health Bureau convened 10 focus groups sessions in Wards 1, 2, 3, and 4 to determine barriers to health care for the District's Hispanic/Latino community. Each of the groups had input into the shaping of the state priorities.

## II. NEEDS ASSESSMENT

In application year 2006, the Needs Assessment must be provided as an attachment to this section.

## III. STATE OVERVIEW

### A. OVERVIEW

The District of Columbia (DC) has a unique status as the nation's capital, and serves the multiple roles of a city, county and state. The District consists of an urban land area of 63 square miles. 57% of the land base is tax-exempt, much of it owned by the federal government, and 41% of the assessed property value is exempt from property taxes, factors that impact upon the resources available to the District government for services to residents. Although DC residents elect a mayor and city council, they do not have voting representation in the US Congress, which has exclusive authority over legislative acts, including those pertaining to the budget. This status, combined with limitations of the local government's authority to tax federal and other property and incomes of commuters, severely limits the availability and allocation of resources.

The District is divided into 8 wards--subdivisions on which political representation is based and public services are administered. Voters in each ward elect a city council representative, and 4 members are elected at-large. As described in the needs assessment section of this application, socio-economic indicators, racial and ethnic composition and health outcomes vary widely across the 8 wards.

The US Census estimated the 2004 population at 553,523, down from the 572,059 count from the 2000 census. The District of Columbia is a majority (60%) African American city. Information from the 2003 American Community Survey indicates that 30% of the population is white, 3.5% is Asian/Pacific Islander and nearly 10% is Latino. Approximately 15% of the population is foreign-born, with 18% of the household population over age 5 speaking a language other than English at home.

The District is characterized by a high rate of poverty--nearly 20% of individuals and 18.5% of families. Median household income and median family income are $42,118 and $50,243 respectively, lower than the US medians of $43,564 and $52,273. And more than 1/3 (35%) of the District's children are members of families living below the federal poverty level (31.3 -- 39.1, 90% confidence intervals). The most recently compiled data on the District's public school population show 84% of the enrolled students are African American and 9.7% are Latino. 64% are low income and 19% are enrolled in special education.

In addition to the high poverty rate, inequality and the concentration of poverty have increased over the past decades. A comparison of pretax income data from the 1970s, 80s and 90s found that the income gap between the highest and the lowest income quintiles was not only great but also growing. The average income of the top 5th of the District's households -- $186,830 in 1999 -- was 31 times higher than the average income of the bottom 5th of households --$6,126. This gap is as great as or greater than any of the nation's 40 largest cities. During the boom years of the 1990s, average income for the highest quintile increased 36% (adjusted for inflation), but only 3% for the bottom quintile.

A study of the concentration of poverty found that contrary to national trends, poverty had not only increased in the District over the past decade but had become more concentrated in certain census tracts. From 1990 to 2000, the number of residents living in extreme poverty tripled, reaching 66,000, and the number of high-poverty census tracts in the city rose from 36 to 43. The number of extreme-poverty tracts more than doubled, rising from 10 in 1990 to 23 in 2000. 24% of poor residents lived in high poverty tracts in 2000 compared to only 9% in 1990. The majority of these tracts are located east of the Anacostia River.

The District, which currently ranks 31st in the nation for maximum TANF benefits, provides lower cash assistance to households with no other income than neighboring Maryland (21st) and Virginia (29th). Over the past 15 years, the maximum benefit level for TANF recipients with no other income has dropped by about 40%, after adjusting for inflation. The current maximum TANF benefit for a single mother of 2 children is $379 per month, or $4,548 per year--only 29% of the federal poverty level! Considering additional income from food stamps, the annual income of a TANF family of 3 is just $750 per month, or about 60% of the federal poverty level.

The metropolitan region is experiencing economic growth and an increase in jobs, but the benefits are concentrated in the suburban jurisdictions. Even jobs generated in the District disproportionately benefit suburbanites. Unemployment has increased over the past year, with the most recent figures (preliminary February 2005) showing an official unemployment rate of 8.2%, varying from 2.8% in Ward 3 to a staggering 15.4% in Ward 8.

One manifestation of extreme socio-economic disparities is the increase in homelessness. According to a HUD report, the District ranked 1st among 13 jurisdictions in the prevalence of homelessness--defined as persons living in shelters--with a point prevalence of 1.4%, or 7% of poor persons. When estimates include persons living in or awaiting transitional housing, the prevalence increased to 2.2%. Average length of stay in shelters was 87.5 days. The number of homeless women with children also increased with more than 150 typically awaiting placement at any given time. Increases have been attributed to several trends: the decline of affordable housing and reduction in public housing units, breakdown in public services for substance abusers and mentally ill persons, and cuts in public assistance and welfare to work policies. The most recent survey conducted by the Metropolitan Washington Council of Governments found an increase of 8.8% (8977) in the number of homeless persons in DC from 2004.

Another analysis by the DC Fiscal Policy Institute found that the number of low income persons increased while the number of affordable housing units declined: In 1990, there were 47,000 renter households with income below $20,000, and 43,000 apartments affordable to them ($500 per month), a shortage of 4,000 units; by 2003, the number of low-income households had increased to 55,000 while the number of affordable rental units had fallen to 31,000 -- widening the affordable housing shortage to 24,000 units.

35% of the District's population spends 30% or more of household income on rent and utilities, a threshold at which families are considered likely to be deprived of other necessary goods such as food. Only 41% of District housing units are owner-occupied, ranging from 21% in Ward 8 to 62% in Ward 4. Furthermore, the most typical household composition is the 1-person household--44% of all households. 13% of households are female headed with related children. 13% are married couple households with no related children. The prevalence of female householders with related children varies from 2.1% in Ward 3 to 33% in Ward 8.

The extreme disparities in income and wealth overlaid with the long-term impact of racism, all concentrated in a small geographic area, without full political sovereignty, present formidable challenges to protecting and improving the public's health.

Since the mid 1990s, the way in which health services to the poor are financed and delivered has undergone many changes, not always in a linear fashion and generally without the inclusion of maternal and child health advocates in the planning process. First was the change from fee-for-service to mandatory managed care for the TANF Medicaid population, followed by an expansion of eligibility based on the SCHIP program. In 1999, the District consolidated its public hospital and network of ambulatory clinics into a single entity, the DC Health and Hospitals Public Benefits Corporation. 3 years later that entity was abolished.

In June 2001, the District, then operating under the authority of a federally-appointed, 5-member Financial Responsibility and Management Assistance Authority established in 1995, closed inpatient and emergency services at the city's sole public hospital, DC General Hospital, and transferred the management of the hospital's ambulatory clinics and community health centers, which along with the hospital were operated under the auspices of the DC Health and Hospitals Public Benefit Corporation, to the private sector. Another umbrella organization, the DC Health Care Alliance, was created to fund and manage the privatization of safety net health services. Before the kinks in the restructured safety net system--the Alliance--were worked out, arrangements began to deteriorate due to the financial instability of the prime contractor's parent corporation. In November 2002, the National Century Financial Enterprises--an Ohio lender that supplied virtually all of the Greater Southeast Community Hospital's (GSCH) cash--collapsed, causing the hospital to immediately close pediatric inpatient and

other services, reduce staff and take other crisis measures, and the parent corporation, Doctors Community Healthcare Corp. which had purchased the GSCH when it was forced into bankruptcy several years ago, eventually filed for bankruptcy itself.

The GSCH, the only acute care and emergency facility located in the southeast quadrant of the city, has remained open despite financial and accreditation problems. The Department of Health (DOH) assumed management of the Alliance, stepping into the administrative role previously played by GSEH. The extent to which the restructuring of the safety net has benefited those who use the system is still being debated. The Alliance is considered to benefit small not-for-profit, neighborhood based clinics and their patients--clinics that are not part of the Medicaid MCOs' networks. These clinics provide culturally and linguistically appropriate care to many of the city's residents who are uninsured but not eligible for Medicaid/SCHIP. In particular, Latino residents have voiced their support for the Alliance at various community forums. More than 20 specialty clinics and health services remain available on the DC General campus, operated by Alliance subcontractors--Ear, Nose, and Throat (ENT) Clinic, Cardiology Clinic, Pediatrics Clinic, Dental Clinic, Gastro-Intestinal (GI) Clinic, Obstetrics and Gynecology Clinic, Surgery Clinic, and Urology clinic.

In October 2003 The Henry J. Kaiser Family Foundation released the findings from the DC Health Care Access Survey, 2003, a telephone survey of a representative sample of 1581 adults . Findings confirmed that 2 characteristics shape access and health status in the District. The population is majority (72%) "minority" (African American, Latino, Asian/Pacific Islander and other). And 36% of the entire population is low income (less than 200% of the federal poverty level, $30, 520 for a family of 3). Latinos (55%) and African Americans (38%) are much more likely to be poor than are whites (20%). The report concludes that the Latino population is particularly vulnerable to lack of access to health services.

Due to the expansion of public programs in recent years, the DC population now has 1 of the highest rates of having health insurance in the US. 91% of those age 18 -- 65 have some form of health coverage, 70% employer based insurance, 11% Medicaid-SCHIP, 5% other and 4% DC Health Care Alliance. (Although the Alliance is not strictly speaking an insurance program, enrollment in the program enables beneficiaries access to Medicaid managed care-like services at no charge.) Only 5% of women in this age group lack some coverage. But although a relatively low proportion of the population lacks health insurance, the impacts vary. For example, 32% of Latino adults lack insurance, compared to 10% of African Americans. Other findings include:
- 9% of the population either relied on an emergency room or reported no regular source of care, with 24% of Latinos being in this situation.
- 36% of uninsured persons rely on emergency room (21%) or had no regular source of care (15%);
- 45% of the uninsured did not have a medical visit in the last 12 months;
- 38% of all Latinos had no medical visit in 12 months;
- Residents (24%) believe HIV/AIDS is the most critical health issue in the District;
- 40% of Latinos report having a problem communicating with providers due to language barriers;
- Although 79% of residents rate their overall experiences in the health care system as excellent or good, the elderly, white and higher income residents report more positive experiences than others.

Medicaid participation is high in the District, due to the high prevalence of poverty. Approximately 24% of the entire population receives Medicaid-SCHIP benefits. The District operates a combined Medicaid-SCHIP program, with eligibility covering up to 200% of the federal poverty level and including parents living with children under age 22. Presumptive eligibility for pregnant women provides coverage for this population, although many otherwise eligible persons are excluded due to their immigration and naturalization status. There are currently 3 managed care contractors that provide services to the TANF and TANF-related, and SCHIP beneficiaries. Another contractor provides carved-out services to children who qualify for SSI and Medicaid. Families may elect to receive fee-for-service Medicaid for these children.

The DC Health Care Alliance provides health care services to approximately 26,400 uninsured District residents with incomes < 200% of the federal poverty level, and who are not eligible for any other

health insurance coverage, including Medicaid. The Alliance is funded entirely by District funds.

The debate on how to finance and deliver health care safety net services in the District is far from over. It appears likely that within the next year, Alliance contracts will be aligned more closely with Medicaid MCO contracts. Advocacy for a hospital to replace the DC General Hospital is very much alive. In 2004, the District entered into a MOU with Howard University Hospital to begin work for a new full service Level 1 trauma center with 200-300 beds to be constructed on the campus of DC General. Considerable debate about the feasibility of another hospital, and its effects upon other hospitals, particularly the floundering GSEH continues.

In June 2005, the chair of the city council committee on health introduced legislation (B16-0348 Universal Healthcare Access Act of 2005) that would require the mayor to recommend within 6 months strategies to ensure universal access to health insurance by no later than December 2010. The bill, which is expected to be considered before the end of the 2005 session and is likely to be approved insofar as only 1 councilmember is not listed as a co-sponsor, lists strategies to include opt-in purchasing to the city's Medicaid program, insurance pools, medical savings accounts, or small employer buy-ins into the District's health insurance.

Mirroring the profound disparities in economic status and health indicators, the District's health care delivery system is 1 of extremes: 3 world class academic medical centers cluster in the northwest section of the city, yet 52% of the population resides in federally designated Health Professional Shortage Areas (HPSA). About 18% of the population lives in Medically Underserved Areas (MUA). Much of the HPSA has been designated as shortage areas for dental services and mental health services as well. According to an annual survey conducted by DC Primary Care Association, the primary care safety net consists of:
- 14 privately operated organizations, 4 of which are federally-funded section 330 community health centers. All together, the 14 entities operate 38 freestanding sites and 3 mobile units;
- 7 hospital affiliated clinics; and
- 3 school based clinics, 1 of which is operated by the Department of Health with federal Healthy Start funds and clinics operated by the Department of Mental Health (number not provided.)

The DC Primary Care Association analyzed the needs, capacity and demand for safety net services and concluded that the existing clinic system is not capable of meeting the demand for primary care services in accessible neighborhood-based settings. Often housed in inadequate physical space, with limited equipment and sometimes thin staffing, few offer the range of services required for adequate primary care. Additionally, linkages to secondary and tertiary care are too frequently tenuous. Moreover, the existing clinics are maldistributed across the city, with relatively few located in the lowest economic areas. DC Primary Care Association therefore embarked on a longterm campaign to raise funds for the capital development of safety net clinics. Raising funds from federal, District and private grants and loans, and providing funds and technical assistance to safety net organizations are the initial steps. But assisting providers to expand and increase their own revenue streams is a primary strategy as well. Within the last year at least 4 private community based health centers have applied for and/or been granted federally qualified health center status and funding.

An analysis of the Behavioral Risk Factor Survey and hospital discharge data commissioned by the DC Primary Care Association and released in January 2005, confirmed that the adult chronic disease burden is concentrated in low income zip codes of the city where there are fewer primary care providers. Furthermore, an examination of avoidable hospitalizations by age group and poverty rate of resident zip code during the period 2000 -- 2003 suggested to the researchers that due to the expansion of Medicaid and the establishment of the Alliance, the rate of avoidable hospital admissions declined to a greater extent in high poverty zip codes (43-59% below 200% of FPL) in comparison to zip codes with less concentration of poverty. The principal investigators, Nicole Lurie, RAND Corporation, and Martha Ross, Brookings Institution, also concluded from their review of these data that there was no evidence of an adverse effect of the closure of DC General Hospital mid-2001.

The District of Columbia Department of Health

The Department of Health (DOH), where the official Title V agency is located, became a cabinet-level department in January 1997. The FY 2005 operating budget of $1,637,183,303 supports 1456 FTEs. 2/3rd of the budget total is based on federal Medicaid payments ($951,289,000) and federal grants ($146,347).

The director of the DOH reports to the deputy mayor for children, youth, families, and elders, a position created by the current administration to give more visibility and attention to services affecting this population. The Department of Human Services and the Department of Mental Health also fall within the purview of that position.
Gregg A. Pane, MD, MPA, CPE, FACPE, FACEP, was appointed director of DOH August 2004. Dr. Pane has more than 20 years of executive level public health experience. He joined the District from the Henry Ford Health System, where he served as System Vice President for Clinical Quality and Safety and Medical Director for Public Policy Initiatives for 2 years.

DOH is responsible for Medicaid (Medical Assistance Administration), contracting with the private sector to provide safety net health services and managing the Alliance (Health Care Safety Net Administration), substance abuse (Addiction Prevention and Recovery Administration), environmental health (Environmental Health Administration) and licensure and facilities regulation (Health Care Regulation and Licensing Administration). Other components are: Emergency Health and Medical Services Administration, HIV/AIDS Administration, Primary Care and Prevention Administration, Health Promotion Administration, and Policy, Planning and Research Administration.

Following his appointment, Dr. Pane continued on-going efforts to centralize support functions and flatten the organizational table. He has delineated 3 principles and 5 strategies to guide DOH. The principles are innovation, measurable results and absolute fiscal and ethical integrity. The strategies are neighborhood outreach and prevention; quality, safe and coordinated system of care; community preparedness; healthy environment; and making government work. Included in the neighborhood outreach and prevention strategy is the consolidation of the Title V-mandated 800 information and referral line with other departmental information services and the establishment of a community outreach team to coordinate and integrate various grants and programs. Outreach and prevention efforts are to focus on language access, health literacy and community partnerships.

The Title V-mandated telephone information and referral operation was consolidated with other DOH information services call centers and hot lines in the communications office of the director of the department. Staff is trained to respond to a broad range of calls. Callers who request the information about maternal and child health services are being re-routed to the 1-800-MOM-BABY HEALTHLINE; however there are reportedly many callers who hang up because of the automated prompts in place before one connects with a live HEALTHLINE counselor. As a result, the opportunity to engage the women who call the 1-800-MOM-BABY HEALTHLINE and probe about status of prenatal care, health insurance, or child care issues and to intervene with referral services or brief counseling has been lost. Because the 1-800-MOM-BABY HEALTHLINE is no longer the first responder for Title V services, call volume has been reduced by close to 50%. Staff believes this change has created a significant gap in services for women and children. For Title V reporting (Form 9), the calls reported are those that are received via referral through the centralized call lines and calls made to the direct line.

In the winter of 2000, under the leadership of the State Center for Health Statistics Administration, DOH completed the 2010 planning process. The final plan, which was released in September 2000, incorporates 20 maternal and child health objectives, 14 adolescent objectives, and 6 family planning objectives. The Maternal and Family Health Administration staff relied heavily on the performance measures required for Title V reporting, and consequently 13 of the 2010 objectives overlap with the Title V measures(http://dchealth.dc.gov/information/healthy_people2010/pdf/2003_2004bipfinal.shtm). In addition to the overarching objective of reducing the infant mortality rate, several focus area objectives are directly related to Title V performance measures: breastfeeding, childhood immunization, early entry into prenatal care, and asthma hospitalization. A biennial implemental plan

for 2003-2004 has been published and a community forum was held summer 2005 to inform stakeholders of progress toward the objectives.

A 5-year health systems plan to guide the certificate of need program continues to be developed.

In 2004, the District passed legislation called the Language Access Act to increase access to government services and benefits. It requires government agencies to provide oral language services to limited English proficient persons, meaning persons whose primary language is not English as well as English speakers with low literacy skills. Each agency is expected to determine what type of oral language service (i.e. telephone language line, bilingual front-line staff) to provide by considering a number of factors, including the agency's size and the type of services it provides. Agencies are also required to provide written translations of vital documents into those languages spoken by the larger language populations served. Medicaid clients are being informed of their right to an interpreter (not necessarily a medical interpreter apparently) in any native language, and translation of all vital documents in Spanish, Vietnamese, Mandarin, Amharic and/or Braille. Print materials are to be designed at a 5th grade reading level. The extent to which compliance with the law has been achieved has yet to be determined.

After forming several strategic partnerships, the DOH State Center for Health Statistics engaged in efforts to expand understanding of health issues among Latinos. Supported in part with a grant from the Centers for Medicare and Medicaid Services and consultants from the George Washington University School of Public Health and Health Services, the Council of Latino Agencies completed in 2004-2005 a household survey in Wards 1, 2 and 4 where the Latino population is concentrated. The interview was based on the Behavioral Risk Factor Survey items and adapted for the target population with input from a community advisory group, the Latino Health Care Collaborative, which continues to work on Latino health issues. In addition to the survey, the Council of Latino Agencies has recently published several reports based on analyses of secondary data to describe changes in the Latino population and to highlight disparities.

## B. AGENCY CAPACITY

The District of Columbia has designated the Department of Health (DOH) Maternal and Family Health Administration (Administration) as the Title V state agency, with responsibility resting with the state maternal and child health officer. Formerly the Office of Maternal and Child Health, the agency was elevated to administration status in February 2001 and, along with several changes made in the DOH organizational table over the past year, is undergoing another proposed realignment as this application is being prepared. The senior deputy director of Maternal and Family Health Administration (or designee) will function as the state maternal and child health officer. That position is currently vacant, with a hire expected by October 1, 2005. Until that time, Marilyn Seabrooks Myrdal will continue to serve as the Title V officer.

Several laws affect the responsibilities and authority of the Administration:
- Title III of the Child and Youth, Safety and Health Omnibus Amendment Act of 2003, DC Law B-15-607 directed the development and implementation of a universal health screening form, the child health certificate and oral health assessment form--the use of the form was implemented in 2005.
- DC Law 6-13 Newborn Screening Requirement Act of 1978, Amendments Act of 1985
- DC Law 3-33 Newborn Health Insurance Act of 1979, which mandates 3rd party payment of newborn metabolic and genetic screening
- DC Law 13-276 Universal Newborn Hearing Screening
- DC Law 7-45, Sec 31-2421, Public School Nurse Assignment Act of 1987, which requires a minimum of 20 hours coverage of a registered nurse per school
- DC Law 10-55 The Administration of Medication by Public School Employees Act of 1993
- DC Law 3-20 The Immunization of School Students act of 1979

- DC Law 6-66 The Student Health Care Act of 1985, which requires students pre-k, 1st, 3rd 5th, 7th, 9th, and 11th grades to have had a comprehensive physical and dental examination and directs the school health division to review the records and notify schools of students who are out of compliance

The Administration's position authority for FY 2005 is 142 full-time positions, 50 of which are supported by federal Healthy Start funding and 57 by Title V monies. 35 are supported by other grants; none are funded by state-appropriated monies. Currently, only 9 positions are vacant, a lower rate than in past years. Since 2000, the position authority has varied from 140 to 158 FTEs. Many of the staff and managers are seasoned District employees. The staff consists of 17 registered nurses (several master's-prepared), 1 LPN, 2 masters of social work, 1 DDS, 1 RD, 1 MD, and 1 CHES. 5 hold MPH degrees. The majority of employees are of African American heritage, reflecting the composition of the District population. There is 1 bilingual (Spanish-English) nurse.

The DOH continues to experience difficulties in retaining staff and hiring qualified candidates. Although the length of time required to advertise, recruit and fill positions has diminished, there is still a substantial time period between when a qualified candidate is identified and when an official offer of employment is made. During this interval, many candidates have accepted other positions. In 2005, personnel functions and hiring decisions in the department were centralized at the director's level, a change from their previous location at the administration level.

The Maternal and Family Health Administration received 2 new grants in FY 2005-- Accessing Health Care for Children and Youth with Epilepsy residing in Medically Underserved Areas in the District of Columbia, and Screening and Treatment for Perinatal Depression. A notice of award for a lead poisoning prevention grant has been received for FY 2006. The purpose of the grant is to conduct assessments and remediation of leaded water pipes, followed by comprehensive risk assessments of children in homes with lead exposure. The 2 federal Healthy Start grants were refunded following a competitive application process. The Healthy Start project in Wards 7 and 8 was awarded a 4-year grant of $2,350,000 annually, CFDA 93.926E, Eliminating Disparities in Perinatal Health, beginning July 1, 2005. The Healthy Start project in Wards 5 and 6 was awarded a 4-year grant of $1,350,000 annually, also beginning July 1, 2005. In anticipation of level funding, several services were adjusted, resulting in a change in staffing. 6 Healthy Start paraprofessional outreach positions and 1 driver will be transferred to the Nutrition and Physical Activity Bureau where the incumbents will be assigned similar outreach duties, allowing their knowledge of their communities to be retained in the Administration.

Several grants are ending this fiscal year--The MCHB-funded newborn hearing screening, and the CDC-supported birth defects registry. As this application is being prepared (July 8, 2005), Administration officials are uncertain as to the possibility of refunding for the hearing screening grant. In the absence of federal funding, Administration officials will consider the possibility of allocating block grant monies to filling the audiologist position and continuing the technical assistance provided to MCOs, hospitals and early childhood development programs.

The future of the birth defects registry is also uncertain. Data collection is linked to maintaining the newborn hospital discharge program, which provides funds to birthing hospitals to support a discharge planner who, among other duties, is charged to identify these infants. An evaluation of the discharge program, which involves surveying mothers utilizing services from the program, is currently underway.

Administration staff is housed in several locations. The data collection and analysis division and the adolescent health division, along with administrative staff, are located in the central office of the DOH. Several adolescent division employees have office space in schools and community organizations. The CSHCN division and the community services division (which is responsible for transportation services and information and referrals) staffs are located in Addiction Prevention and Recovery Administration office sites, several blocks from the central office in space that has generated concerns from employees' about environmental health and safety. Healthy Start staff is located on the campus of St. Elizabeth's Hospital through December 2005, when they will relocate to the campus of DC

General. Nutrition program staff, soon to be a part of the Administration, are located at sites throughout the city, with administrative staff headquartered in offices in Ward 6. With the exception of several outreach employees, Administration staff has desk top computers and the Internet. All staff has been trained in use of the Internet and in software relevant to their work.

The Administration leases several vans for transport of clients and staff. From 1994 to June 2003, Healthy Start operated the Maternity Obstetric Mobile (MOM) unit, a 40 feet unit with 2 fully equipped examination rooms, audio-visual equipment, and health education materials. The unit serves the project area, providing a range of curbside services (depending upon available staff)--pregnancy tests, health screening, health education, immunizations and enrollment in case management. The unit was retired in June 2003, and a replacement ordered. The new unit will have a dental chair and a dental hygienist will provide oral health screening to pregnant and postpartum women. It is expected to be available for operation by the beginning of FY 2006.

The Administration maintains a Maternal and Child Health Resource Center at the central DOH office. A variety of print and video materials are available to DOH staff and staff of community based providers. The Healthy Start project maintains a library of training materials at its site.

In FY 2003 Administration employees petitioned to and eventually voted to form a bargaining unit. Approximately 145 of the then-158 Administration positions became subject to union scale wages, resulting in a nearly 8% increase in labor costs for FY 2004.

In the summer of 2003, the Administration engaged a consultant recommended by MCHB to work with management to complete the CAST 5 analysis. Following the preliminary work, senior staff and other managers completed a 2-day training and retreat on September 10-11, 2003. The 2nd phase of the analysis took place June 29-30, 2005. The results have been used to define the Administration's technical assistance needs for this application. The report will be circulated to the senior deputy director for Maternal and Child Health Administration when the position has been filled. An orientation and strategic planning retreat for the Administration will be convened at that time.

The Administration participates in AMCHP, CityMatCH and APHA, sending staff to conferences and skills training sponsored by these professional organizations and making presentations on special projects. Last year Marilyn Seabrooks Myrdal was selected by the AMCHP membership as the Region III representative to the executive council and she was recently elected as the Region III representative to CityMatCH.

Special Needs Capacity

Joyce Brooks, MSW, continued to direct the CSHCN division, which consists of 25 FTEs, funded by several federal grants in addition to Title V--newborn hearing screening, sickle cell disease, and access to care for children with epilepsy, The childhood lead poisoning prevention program, which receives funding from the Department of Housing and Urban Development and the Centers for Disease Control and Prevention, is being moved from the DOH Environmental Health Administration to the Maternal and Family Health Administration, Child Health Services Bureau, which will replace the CSHCN division. Currently, 5 of the 25 positions are vacant. In addition, there is no audiologist on staff, a previously grant funded position that is key to the operation of the newborn hearing screening program. There is 1 RN and 1 LPN on the staff.

CSHCN division staff members are active in an array of inter- and intra-agency and public-private partnerships that focus on a broadly defined special needs population, including the DC Intra-agency Coordinating Council (Part C) and Developmental Disabilities State Planning Council, and coordination with the DC Early Intervention Program (DCEIP).

The division coordinates with a range of government agencies and private sector organizations, a few of which are described in this section of the application. Since June 2002, the Administration has had a MOU with the Office of Early Childhood Development (OECD), which includes the Early Intervention

Program (DCEIP) in its scope of cooperative activities. The CSHCN division is responsible for coordination with OECD. The MOU covers database linkage and tracking of clients across various services and programs administered by the 2 agencies; training of Healthy Start and information and referral staff in Part C program guidelines and services; and jointly offering training for Head Start and pre-kindergarten programs, mental health providers, child care providers and early intervention programs. The Administration, OECD and various other stakeholders developed a universal health form now being used by schools and all other District early care and education programs. A protocol for reciprocal referrals and for the provision of client specific information was developed to increase the participation of eligible children in Part C and other programs for children with special health care needs.

OECD offers periodic training to its subsidized child care providers to help them to meet licensure requirements. These training sessions are now incorporating the dissemination of information from the Administration. Although the MOU calls for a co-funded and co-located position to coordinate efforts and carry out the MOU, that position has been vacant for more than 12 months. The MOU must be renewed periodically, and it was sent to the DOH director for signature February 11, 2005.

Coordinative activities with the OECD have been supported by a 3-year Early Childhood Comprehensive Systems grant from MCHB, now concluding its 2nd year. Focusing on development from the prenatal period through age 8, the grant is being used for environmental scanning and resource mapping, with the expected end result being a realistic plan for services integration. The CSHCN division participates with other city initiatives focusing on early childhood, such as the Early Learning Opportunities Act Grant (ELOA), addressing ages 3 and 4, the Kellogg Foundation SPARK grant for "Supporting Partnerships to Assure Ready Kids," addressing ages 3 to 5, and the DC Education Compact which is developing a Strategic Plan for DC Public Schools, to overlap age cohorts and build a system based on a developmental definition of childhood (0-8).

## C. ORGANIZATIONAL STRUCTURE

Following legislation in 1997 that established the DOH, a mayoral administrative issuance, followed by a departmental organization order, designated the Administration as the Title V state agency for the District of Columbia. Marilyn Seabrooks Myrdal, MPA was appointed the state chief maternal and child health officer to direct the Administration (then the Office of Maternal and Child Health) May 2000. Until recently, the maternal and family health programs continued under the purview of the senior deputy director of health promotion, a position also responsible for the Office of Nutrition Programs. As this application is being prepared, the Administration is being realigned: DOH management is replacing the position of senior deputy director of health promotion with the senior deputy director of the Maternal and Family Health Administration, and bringing nutritional services into the Administration. The senior deputy director will report directly to the DOH director. Recruitment for the position is underway with a decision expected by October 1, 2005.

In this section of the application, the current organizational structure will first be described, followed by a description of the plans, as they are known to date (June 30, 2005) for the realignment.

For several years, maternal and family health programs and Title V functions were organized around 7 divisions. An administrative officer and staff-- responsible for procurement, personnel and budget issues, as well as training and staff development--who previously reported to the state chief maternal and child health officer were transferred to the chief of staff, office of the deputy director of health promotion in Fiscal Year 2005. (See organizational tables, appendix) The division officers and their dates of appointment are as follows:

Data Collection and Analysis Deneen Long White 1/98-6/05
Family Services Diane Davis, RN 10/98-present
Children with Special Needs Joyce Brooks, MSW 1993-present

Community Services Eleanor Padgett, LICSW 5/01-present
Policy, Planning and Evaluation vacant except for 10 month period 02-03
Adolescent Health Colleen Whitmore, MSN 9/01-present
Special Initiatives Felicia Buadoo-Adade, RD 10/03-present

Division directors meet weekly to report on the status of programs and to discuss any issues or program barriers requiring coordination across divisions. Information about the Administration and DOH is shared with management staff during these weekly meetings.

The 2 federally funded Healthy Start projects, which are the largest sources of funding other than Title V, family planning and the home visiting initiative, constitute the family services division. The community services unit includes information and referral, transportation services, and community education. The responsibilities of the special needs division and the data division are described in the section on special needs and other capacity respectively.

The Realignment

The Maternal and Family Health Administration, to be headed by a senior deputy director, is being realigned as 5 bureaus as this application is being prepared. The purpose is to align programs that are population based or service driven and to assure an integrated approach to service delivery. The mission of the Maternal and Family Health Administration continues to be to promote the development of an integrated community based health delivery system, to improve health outcomes, to foster public private partnerships for women, infants, children, CSHCN, adolescents, families (including fathers) and seniors. The realignment becomes effective October 1, 2005. The DOH director is preparing a transition plan.

The Perinatal and Infant Care Bureau is responsible for the federally funded Healthy Start projects, which provides nurse case management for at-risk pregnant women in Wards 5, 6, 7 and 8. Women and their infants are retained in case management for 24 months after delivery, with coordination of well baby care and special needs referrals, contraception and other interconceptional care of the women. This bureau will also be responsible for the implementation of a newly awarded 1-year MCHB grant to promote perinatal depression screening and referrals for treatment. In addition, the Perinatal and Infant Care Bureau will operate a number of Title V-funded services and activities, namely the SIDS bereavement and education program and the newborn home visiting program, which includes distribution of free cribs to families that do not have safe sleep arrangements for newborns, and funding of discharge planners in local birthing hospitals. The bureau will also continue to be the liaison to the District's child and infant mortality review functions, currently located in the Office of the Medical Examiner, an office that reports directly to the mayor.

The Child Health Services Bureau will be responsible for all CSHCN functions--the genetic and metabolic, and newborn hearing screening programs, sickle cell disease program, and the grant-funded awareness and access to care for children with epilepsy. The childhood lead poisoning prevention program, formerly a component of the Environmental Health Administration, will be a new responsibility for this bureau.

The Nutrition and Physical Activity Bureau is responsible for the Special Supplemental Program for Women, Infants and Children (WIC) and the administration of other grants funded by USDA--Loving Support Breastfeeding Program (a partnership with Howard University Hospital), Food Stamp Nutrition and Education Program, Commodity Supplemental Food Program, Farmers' Market Nutritional Program, Folic Acid Initiative and the Employee Wellness Program.

The School Health and Adolescent Health Bureau will be made up of 3 divisions--school health, adolescent health and oral health. The school health division, staffed with 1 FTE, is responsible for the school health nursing program (see section on interdepartmental coordination for description), the Woodson Senior High School Wellness Center (funded with Healthy Start grant monies), and the vision screening program, which was formerly conducted by the CHSCN division.

The Adolescent Health Division will have responsibility for the grant-funded abstinence education program, the TANF-funded teen pregnancy prevention program, and 2 programs that will continue to be supported by Title V monies--youth violence prevention, and the health and sexuality education initiative. Oral health activities are being placed in the Oral Health Division, staffed with a public health dentist. Division responsibilities include directing a federal grant--oral health integrated system development--to rebuild the structure for a state oral health function, including the formulation of standards for school based oral health services and child oral health assessment and the operation of a small school based dental sealants project. Another oral health grant, in its final year but with substantial funds available for carry over, has been used to work in conjunction with CNMC to establish oral health services at 2 public schools dedicated to CSHCN, and to use telemedicine to extend such services to other schools serving high numbers of CSHCN.

The 5th bureau, the Adult and Family Health Services Bureau, will be responsible for the men's health initiative, the women's health initiative and family planning, which are currently a part of the Administration's special initiatives division. The bureau will be responsible for transportation, as well as a sexual assault prevention program that is being transferred from the Primary Care and Prevention Administration.

The status of the Administration's data collection and analysis division is uncertain, pending further review at the departmental level and by the new senior deputy of Maternal and Family Health Administration. Decisions about the assignment of nutritional services and lead poisoning prevention surveillance positions have yet to be announced.

Incumbent division directors have been informed that they must apply for the positions of bureau chiefs. However, the new positions are at a higher grade and therefore not all directors are eligible to apply for the positions in which they are currently functioning.

## D. OTHER MCH CAPACITY

Title V funds the majority of the 10-11 FTEs assigned to the data collection and analysis division. 4 of the incumbents hold masters degrees. The project activities carried out in the division include Healthy Start MIS, Pregnancy Nutrition Surveillance System (PNSS), Pregnancy Risk Assessment Monitoring System (PRAMS), birth defects registry, ECCS grant data collection, and the SSDI grant, which supports various database linkages and integration efforts.

Because the Administration is undergoing a major realignment, and the centralization-decentralization of surveillance and management information systems is being reassessed throughout the department, a needs assessment process will be developed to evaluate existent data systems and staffing to meet the needs of the new organizational structure, fulfill state level data requirements and grant reporting functions, and monitor program and contractor activities.

The Administration is faced with several critical data related issues. 1 issue involves the costs and relevant benefits of existent and developing surveillance, tracking, and websites over time. PRAMS and PNNS have been in operation for over a decade. Healthy Start MIS captures client and case management services and has been expanded to capture data from a variety of outreach activities. DC Kids Link is a developing population-based system linking child related data from a variety of sources. UNITS is a new system for tracking hospital and referral activities for the newborn screening programs, the newborn discharge program, and for the birth defects registry. Finally, the school health information system is a pilot project designed to gather school health data on approximately 16,000 of the District's school children. Data on each of the latter 2 systems are maintained by a private contractor.

Currently, DOH surveillance functions are decentralized and scattered throughout the organization. At issue is whether to merge most of the data functions, or combine some of the data groups, or make no major changes. Finally, the organizations will assess existent and future staffing patterns. Web-based applications and data warehousing may require reeducating existent staff or require staffing with different skill sets.

In addition to their professional training and/or organizational experience, at least 10 Administration staff members parent children with special needs. These staff were not necessarily hired to advocate for the special needs population; their responsibilities are integrated throughout the functions of the Administration. Nevertheless, their ongoing experiences with accessing education, social and medical services provide a valuable asset for the entire staff. Marilyn Seabrooks Myrdal, the Administration's representative to AMCHP, represents AMCHP on the Family Leadership Caucus, a group formed to advice and guide AMCHP and state Title V programs regarding the roles and responsibilities of families.

The grant to enhance access to services for children with epilepsy will fund a family advocate to be located with each of the 4 Medicaid MCOs.

In 2004, the Administration dedicated a position for Hispanic Health Services. The individual who filled the position (now on extended leave) is a bilingual registered nurse and health educator. She organized an Hispanic Health Coalition of representatives from community based organizations in the Latino community. The coalition was instrumental in organizing focus groups to elicit data for the needs assessment described in this application and continues to advise Administration management on meeting the needs of the Latino MCH population. Another Administrator employee, hired as a liaison to the Asian and Pacific Islander community, speaks Mandarin, Cantonese and Vietnamese.

The DOH has formed an office of language and communications in order to comply with the recently passed language access law. This office arranges for translation of departmental materials.

## E. STATE AGENCY COORDINATION

Intradepartmental Coordination

During the reporting period, the Administration continued to work with the WIC and the immunization programs, both of which are located in the DOH. See NP# 11 and 7 for a description of activities. The Administration applies Title V funds to the support of the lead poisoning prevention program, which is also supported by CDC and HUD grants. See SP# 3. WIC and other nutritional programs and the childhood lead poisoning prevention programs are being moved to a new component of the Administration--Nutrition and Physical Activity Bureau. Lead screening will be located in the Child Health Bureau.

Coordination with Medicaid-SCHIP
Administration efforts to establish formal relationships with its sister agency--the Medical Assistance Administration--and the Medicaid managed care organization (MCO) contractors, which have been underway since the initiation of Medicaid mandatory managed care in the mid 1990s, are finally coming to fruition. By December 2004 the 3 MCOs and the CSHCN carve-out MCO had signed MOUs outlining the respective responsibilities of the MCO, MAA and the Administration. The agreements focus on the care coordination and continuity of care for those MCO enrollees who are also Administration clients, including but not limited to Healthy Start participants. Representatives of MAA, the Administration and the MCOs have been meeting monthly since January 2005, with the initial objective being to share information about programs, services and barriers. It is expected that in FY 2006, representatives will begin work on case management standards and protocols.

Prior to the MOU, Administration employees were trained on procedures for referring potentially eligible persons to Medicaid-SCHIP enrollment sites. Healthy Start nurse case managers work to enroll and maintain certification of their clients, and to assist them as necessary with the selection of a

primary care provider. Clients are also instructed in the use of a managed care provider.

Substance Abuse
The Administration negotiated an MOU with its sister agency, the Addiction Prevention and Recovery Administration (APRA), March 2003 to use Healthy Start funds to provide pregnancy test kits for women who present for substance abuse services at the Women's Services Clinic and other APRA-operated facilities. Pregnant women, as well as women up to 3 months postpartum, are referred to Healthy Start for case management. Prior to the agreement, APRA clients had not been routinely tested for pregnancy and consequently their substance use related services were not well coordinated with reproductive health and/or HIV services. The 2 agencies established a reciprocal referral system, and a jointly funded paraprofessional health education position is located at the Women's Services Clinic to coordinate referrals, joint case conferences and staff training. Staff report considerable demand for the testing kits.

HIV/AIDS Coordination
As a result of participation during 2001-2002 in a special CityMatCH project, the Perinatal Urban Learning Cluster, and later in the Association of Maternal and Child Health Programs (AMCHP) Perinatal HIV Transmission Action Learning Lab, the Administration strengthened its relationship with its sister agency, the HIV-AIDS Administration (HAA), and the Ryan White Title IV grantee to develop a policy statement on perinatal transmission. In 2003, a CDC representative met with the Clinical Advisory Workgroup and DOH staff to discuss the implications of rapid testing technology on perinatal HIV control. Following the discussions with the CDC representative, assigned staff from the Administration, the HIV/AIDS Administration, APRA and a panel of 6 District physicians prepared the March 2003 Final Draft Revised Recommendations for Universal HIV Screening of Pregnant Women. Recommendations included the incorporation of routine HIV testing as a normal part of prenatal care, including universal retesting in the 3rd trimester. Under the draft recommendations, providers can adopt "opt-in" or" opt-out" protocols. Clinical guidelines at www.hivatis.org (currently http://aidsinfo.nih.gov/guidelines/default_db2.asp?id=66) are recommended. The March 2003 draft was to have been reviewed by the HIV/AIDS Administration prior to forwarding to the DOH director for action. To date, the District's official draft policy is based upon the 1995 US Public Health Service recommendations.

Interagency Coordination

Coordination with various agencies is discussed throughout this application-- in the overview as well as the annual report/annual plan sections. See performance measures dealing with CSHCN for a description of activities with early intervention and child care agencies, and other agencies that serve children with special needs.

Coordination with Public School System
DC public schools are required by the District of Columbia Public School Nurse Assignment Act of 1987 to staff a minimum of 20 hours per week of nursing services in public schools. High schools are to have a registered nurse on duty at least 40 hours per week. The operation of the school nurse program has undergone a number of changes over the past 10 years. For many years the Department of Health (then the Commission of Public Health) operated the program, with nurses employed directly by the commission. In the late 1990s the responsibilities were transferred to the DC Health and Hospitals Public Benefits Corporation (PBC), which was also responsible for the operation of the DC General Hospital and the public community health centers. When the PBC was abolished and the entire safety net system was privatized in 2001, the District contracted with the Children's National Medical Center, a regional tertiary care institution, to operate the school nurse program. The DOH Safety Net Administration was created to oversee the entire privatization effort and contracts, with the Maternal and Family Health Administration retaining some responsibilities for school nursing policy and standards development, evaluation and monitoring.

The Administration's relationship with the school system continues to evolve. The advent of charter

schools during this period increased the cost burden insofar as charter schools are eligible to request school nurse services; but 36 of the 57 charter schools do not have the required nursing services. Additional funds were requested in the FY 2006 budget to meet this demand, but only partial funding was approved.

In 2004, the Administration hired a masters-prepared registered nurse to support coordination with the schools and the school nurse program. This school health liaison is currently the sole staff person in the new Adolescent and School Health Bureau, School Health Division. The proposed FY 2006 budget includes funds to provide additional school health services.

The school health liaison also represents the Administration on the city wide Task Force on Immunization. In past years, DOH has had to redeploy staff at the beginning of the school year to staff express clinics and track down children whose immunization records were not up to date. Schools have denied admission to students who were not in compliance with immunization requirements; however, it appears that the annual "immunization crisis" will be avoided this September: 90% of the schools have > 90% of students properly immunized.

The school health liaison is in daily contact with the school health nurses program regarding the reporting and resolution of incidences and urgent issues, for example, nurse coverage of schools to meet legal requirements, particularly at the beginning and end of the term. Schools have very different needs based upon location, enrollment, and socio-demographic characteristics of the students and neighborhoods, and the numbers and needs of medically fragile students who have been mainstreamed.

It is not uncommon for a child to transfer in without notice and the necessary resources in place to meet her/his needs for nursing support. Not all school nurses have recent training sufficient to meet specific, individual needs. It then becomes the responsibility of the Adolescent and School Health Division staff to work with those involved to find a solution.

In spring 2005, the Adolescent and School Health Division implemented a systematic school health monitoring protocol, which supplements the monitoring of the physical facilities and equipment in the school nurse suite conducted by the Safety Net Administration. The inadequacy of the space, equipment and Internet access of many school nurse suites has been noted and efforts are proceeding to incorporate standards published by the National Association of School Nurses.

Mental Health Coordination

In March 2001, the Administration, through the Healthy Start program, set the stage for an important collaboration with the Commission on Mental Health, now the Department of Mental Health (DMH). The Parent and Infant Development Program (PIDP), located in the Children and Youth Services Administration, DMH, provides outpatient evaluations, psychiatric, psychological and psychotherapeutic services to pregnant women, their families and children up to age 5. An MOU with the PIDP DMH was signed February 2003 and Healthy Start funds were transferred to pay 2 LICSWs to case manage referrals of Healthy Start clients who screen positive for depression and/or appear to have other mental health disorders. The Administration worked with Mary's Center for Maternal and Child Care (a 330 grantee) to submit on June 2, 2004 a grant application to MCHB for a 1-year program to introduce perinatal depression screening throughout the District of Columbia. Notice of an award for $250,000 was received spring 2005. Implementation will begin October 2005.

The Maternal and Family Health Administration is among the many government agencies participating in a private-public partnership to improve learning outcome for young children through the alignment of programs for children ages 3 -- 6 and transition between school and preschool. 10,000 of the 16,000 3-4 year olds are estimated to be enrolled in some type of early education programs, but fewer than 33% attend a program accredited by the National Association for the Education of Young Children. SPARKS (Supporting Partnership to Assure Ready Kids) is part of a national initiative of the W.K. Kellogg Foundation led by the National Black Child Development Institute. 3 large child

development centers have been selected as anchor sites in each of Ward 1, 7 and 8. Each anchor is paired with an elementary school and staff and parents will adapt and implement preschool-school transition strategies affecting 1000 preschool children. The Administration's unique contribution to this effort is to incorporate the 6 schools in the school health information automation pilot project. See NP# 7. In 2005, the partners worked to develop universal standards for school readiness for 4 year olds.

Family Services
The Administration and the Child and Family Services Administration (CFSA), Department of Human Services, negotiated a memorandum of understanding (MOU) effective December 2002 through September 2004 (signed April 23, 2003) for joint case management of drug exposed infants. The MOU was developed in response to the varying practices in hospitals for reporting "substance-positive infants" and the Child Fatality Review Committee's long standing recommendation to improve and coordinate home visiting services to high risk families. Through the Administration's home visiting program, many substance using families are identified and targeted for continued assessment and treatment; however once the infant leaves the hospital, many refuse follow up services. The joint case management incorporates the Administration's skilled nursing assessment and related services by Healthy Start nurses and the CFSA's family focused case management. Law 14-206 Improved Child Abuse Investigations Amendment Act of 2002 strengthened the District's investigations of child abuse and neglect. Among other provisions, the law changes the definition of child neglect to include drug exposure and positive drug test in newborns and requires reporting of positive drug tests. But the language does not mandate a finding of neglect based on drug exposure alone. The legislation was not supported by dedicated funding for implementation.

During 2004-2005, due to the influx of these cases, Healthy Start nurses reached and exceeded their caseloads, reducing the resources for prenatal and interconception care coordination as required by the Healthy Start grant. Administration nurses funded through Title V also have high caseloads, and referrals to other case management programs in the city stretched private resources. A new MOU that requires CFSA to provide funding for 2 FTE Healthy Start nurse case managers to provide services to these cases is ready for signatures.

Other collaborations and coordination of activities are described in the performance measures sections of this application.

## F. HEALTH SYSTEMS CAPACITY INDICATORS

Over the past 5 years the Administration has gradually improved its capability to acquire and review capacity and other indicators data. The MOU with the State Center for Health Statistics was signed in August 2003, and the data collection and analysis officer has direct access to the annual birth records and other data in April prior to block grant submission in July. Problems with quality data continue however. (See notes Form 11.)

Examination of the 6 health systems capacity indicators shown on Form 17 suggests limitations in capacity to serve women and children, especially low income children. Limitations in the capability to obtain and interpret the data, combined with problems with the quality of the data pose barriers to the description and analysis of systemic issues and the design of effective interventions. The recently completed (June 2005) CAST-5 prioritization process identified access to timely program and population data from relevant public and private sources as the top capacity need of the Administration.

1. Asthma hospitalization rate -- The rate of children hospitalized for asthma (ICD-9 Codes: 493.0 - 493.9) per 10,000 children less than 5 years of age - The 2003 rate of 12.5 is an astounding reduction from 58.4 in 2000. Estimated rates may be affected by variation in estimates of the denominator.

The District has recently made considerable progress in describing asthma morbidity. Using funds from a cooperative agreement with CDC, the Control Asthma Now (DC CAN) staff completed and

disseminated a state asthma prevention and control plan in cooperation with numerous stakeholder organizations. An epidemiologic profile presented data from 3 existing sources: the BRFSS, mortality files, and inpatient discharge data. Post 9/11, the District has been conducting an ongoing syndromic surveillance system on 7 syndromes, 1 of which is respiratory and includes asthma. 8 hospital emergency departments participate. Beginning in 2004, asthma is being coded as an additional syndrome. The DOH Bureau of Epidemiology and Health Risk Assessment (BEHRA) is responsible for this system. BEHRA also maintains a list of High Incidence Flag Day among emergency departments. A flag represents a higher incidence of a syndrome than normally would be expected. These days are reviewed for asthma as the primary diagnosis or chief complaint.

With the exception of the hospital discharge data, which are acquired by the DC Hospital Association from its member hospitals, the aforementioned components of the surveillance system are collected and maintained by the DOH. In view of the issues of acquiring and analyzing data across DOH administrations, CDC recommended that the project be transferred from Maternal and Family Health Administration to the Primary Care and Prevention Administration. The transfer was completed winter 2005.

DOH is developing an asthma data warehouse, which is expected eventually to include environmental surveillance and Medicaid cost and utilization data, emergency department visits, over the counter pharmaceutical use, school absenteeism, and workmen's compensation data.

2. Medicaid enrollees < 1 year with at least 1 periodic screen -- The reported screening rate has increased from 34.8% in 1999 to 75.7% in 2003, a very substantial improvement but still below mandated targets. In all age categories, the participant ratio is much lower for the medically needy enrollees, who are fee-for-service, than for the categorically needy, most of which are in managed care.

3. SCHIP screening - The District SCHIP and Medicaid are a combined program. The Medicaid enrollee screening rates include SCHIP beneficiaries. The 2 programs are fully integrated, enabling family members to retain the same provider despite changes in eligibility and age.

4. Women > 80% Kotelchuck Index -- The percent of women giving birth who met this standard decreased from 77.4 in 1999 to 59 in 2003, a troubling trend. Missing data on trimester of entry into prenatal care and number of visits for approximately 15-16% of births make it difficult to use this measure to assess capacity of the District's health care system. What is does seem to suggest is the need for more attention to measurement issues, especially vital records reporting.

5. Comparison of Medicaid, nonMedicaid and total MCH populations -- Administration staff has not been able to obtain and link the Medicaid recipient file with the 2001 - 2003 birth data. Access to identifiers in the birth file, which is necessary for matching cases, is reportedly incorporated in the MOU with the State Center for Health Statistics Administration; however, barriers in operationalization remain. Therefore, reporting on Form 18 reflects an estimate only.

6. The District's combined Medicaid-SCHIP covers eligible families of minor children (to age 22) up to 200% of the federal poverty level. As a result of Medicaid-SCHIP and the DC Health Care Alliance (see overview section), the District has 1 of the lowest levels of uninsuredness in the US. However, as the various EPSDT participation measures indicate, the extent to which Medicaid beneficiaries are receiving services to which they are entitled is an issue.

7. Medicaid enrollees age 6 -- 9 receiving dental service -- The percent of Medicaid and SCHIP enrollees reported to have received any dental service during a year increased from 22.9% in 1999 to 31.5% in 2002, declined again to 23.1% in 2003 and increasing in 2004 to 36.2%, suggesting that attention resulting from litigation and the establishment of an oral health program in DOH may be having an effect. Oral health status and access to oral health services continue as serious problems for DC children and their families. See section Priorities, Performance, and Program Activities, State Priorities, oral health and NP#9 for more information.

8. Percent of State SSI beneficiaries less than 16 years old receiving rehabilitation services from the State Children with Special Health Care Needs program -- The Administration continues to be unable to report this measure. See TVIS historical notes for performance measure 1.

9(A). Ability to access policy and program relevant information and data - As indicated on Form 19, the Administration has access to all of the listed electronic databases, 2 of which (PRAMS and birth defects surveillance) are located in the Administration's data collection and analysis division. The birth defects surveillance system is being installed (see NP#3) but several years will be required before the system yields data for planning and policy development purposes.

Although several staff members have the training and skills to obtain data from birth records, discharge data and Medicaid claims files for program planning and policy purposes in a timely manner, limited resources and the need to respond to urgent issues constitute formidable barriers to the generation of analytic reports on a periodic basis. As a result, the Administration and its community partners often lack data to anticipate and address policy issues and to plan effective interventions. For example, the information to complete Form 18 comparing Medicaid/SCHIP and nonMedicaid-SCHIP outcomes is not readily available. The quality of the data also limits, for example, the proportion of birth records with missing data on trimester of entry into prenatal care.
9(B). Ability to determine percent of adolescents in grades 9-12 who report use of tobacco - Although the District public school system participates in the YRBSS, in 2001 the school level participation was insufficient to meet sampling criteria. The 2003 survey had 100% school participation http://www.cdc.gov/mmwr/PDF/SS/SS5302.pdf and comparisons can be made with 1999 and prior years data. As shown in the table below, prevalence of reported tobacco use by both DC male and female students has decreased significantly since 1999.

Reported tobacco use in past 30 days
Sex T F M
Year
2003 14.7 (±2.0) 13.2 (±2.4) 16.5 (±3.3)
1999 23.3 (±2.5) 21.2 (±2.9) 25.9 (±3.6)
Source: CDC YRBSS http://apps.nccd.cdc.gov/yrbss/QuestYearTable.asp?path=byHT&ByVar=CI&cat=2&quest=504&year=Trend&loc=DC

Insofar as the District may have a relatively high proportion of out-of-school youth, YRBSS data do not include this segment of the youth population. Nor is the private school population included.

9(C).Ability to determine prevalence of obese and overweight children -- As described above, the District public school system participates in the YRBSS and therefore DOH can obtain estimates of the self-reported prevalence of overweight among adolescents enrolled in public schools grades 9 -- 12. As shown below, there has been no change since 1999 in the proportion of public school 9 -12 grades who describe themselves as overweight. In addition to the limitations of the YRBSS noted above (9(B)), self reported overweight is subject to considerable variation due to factors in addition to BMI.

Describe themselves as overweight
Sex T F M
Year
2003 13.5 (±1.9) 11.5 (±2.1) 15.5 (±3.0)
1999 12.7 (±1.5) 11.3 (±2.2) 14.2 (±2.2)
Source: CDC YRBSS http://apps.nccd.cdc.gov/yrbss/QuestYearTable.asp?path=byHT&ByVar=CI&cat=2&quest=504&year=Trend&loc=DC

The District does not currently have an estimate of the prevalence of childhood overweight and obesity.

In response to a study of the prevalence of obesity and overweight of Medicaid MCO patients, in June 2005 the Medical Assistance Administration (state Medicaid agency) organized the Obesity Prevention Advisory Council. Each Medicaid MCO is represented as well as the Administration and other DOH staff. The council has a clinical orientation and reports to the Physicians Work Group. The council is charged with making recommendations on the use of a universal high risk assessment tool.

# IV. PRIORITIES, PERFORMANCE AND PROGRAM ACTIVITIES

## A. BACKGROUND AND OVERVIEW

During this reporting period, the Maternal and Family Health Administration (Administration) continued to focus on the priorities delineated in June 2000, working within the Department of Health (DOH) and in an environment that has undergone significant change over the past 5 years. The continuing restructuring of the District's safety net for the provision of health care for the poor, hospital closures and financial crises, the aftermath of September 11, 2001 and the increasing emphasis in public health on responding to potential bioterrorism, coupled with diminished tax revenues affected the Administration's resources and activities. Changes occurred within the DOH as well. Throughout the period 2000-2005, the Administration continued to focus on its 5-year objectives and long term priorities. Each year from 2000 to 2004 prior to the submission of the Title V block grant application, senior staff met to review and discuss annual performance measures. As a result, a few of the priorities were slightly modified, for example, changing "establish" to "institutionalize", but remained essentially the same.

In preparation for the July 2003 block grant report, application submission, and 5 year needs assessment, staff and consultants considered the findings from the MCHB-sponsored national survey of CSHCN. Reviewing the DC data in comparison to US data as well as information collected as a result of activity on categorical grants, targets for the performance measures specific to CSHCN were set.

This spring the Administration completed the collection of data for the 5-year needs assessment. As described in the needs assessment section of this application, the data collection and analysis staff compiled data from numerous sources to describe the District's maternal and child health populations. These data were presented to forums and focus groups, and the report was widely distributed. Several focus groups were convened to elicit input on residents' needs. The focus groups included groups dedicated to teens, parents and Latinas. On June 27, 2005, 9 Administration staff members met in a 3-hour priority-setting exercise to discuss the needs assessment findings, both the trends outlined in the quantitative analysis and the comments from the focus groups, as well as their own experiences in administering programs and initiatives. Also taken into account were the District's Healthy People 2010, an emerging state health plan to guide the certificate of need process, the state Medicaid plan, the developing state adolescent health plan, and planning for categorical grants.

The priority-setting exercise gave special attention to the issues that were unanimous across focus groups. Next, the staff reviewed the 2000 priorities and discussed whether any should be retained for the 2006-2010 period. It was generally agreed that considerable progress had been made toward 3 priorities; therefore, they were moved off the high priority list. It was noted that changing priorities did not mean work on these issues and programs would cease. A 4th priority, monitor the effects of welfare repeal on health status, had yet to receive much attention and now seemed beyond the scope of existing resources, and it too from removed from the priority list.

The staff then formulated 5 new priorities. In the next section of the application, the status of and plans for each of the priorities is described. First, the status of priorities set in June 2000 is described, including the 4 priorities that will not be continued into 2006-2010. Next, the status of 3 priorities established in 2000 and carried over into the 2006-2010 period is described. Then 5 new priorities are described. Priorities are numbered only for purposes of reference in discussion.

The Administration will continue to report on the same 7 state performance measures delineated in previous years due to their emphasis on issues of considerable importance to the District maternal and child population:

- Increase the % of women who receive adequate prenatal care;
- Increase EPSDT participation;
- Reduce the prevalence of lead levels exceeding 10ug/dl among children through age 6;

• Reduce the prevalence of tobacco use among pregnant women;
• Reduce the proportion of births resulting from unintended pregnancies;
• Reduce the percent of women that give birth with no prenatal care or prenatal care initiated in 3rd trimester; and
• Reduce the incidence of repeat births for teens less than 19 years of age.

The Maternal and Family Health Administration recognizes that the needs assessment is an ongoing process of reviewing new information and reassessing priorities. Toward that end, the Maternal and Child Health Officer is recommending to the director of the Department of Health that a Maternal and Child Health Work Group be convened to review the findings of the recently submitted needs assessment and discuss the implications for the development of policy in the District. The Work Group would be charged with developing a short-term plan for approaching and informing local policy makers on ways to improve the health of women, children and families.

The recommended composition of the Work Group will include maternal and child health services providers, including CSHCN, advocates and representatives of government agencies.

## B. STATE PRIORITIES

Discontinued priorities

Infrastructure building: Establish (and institutionalize) a coordinating committee to strengthen system links among health, social services, juvenile justice, public schools, mental health, protective services and developmental disabilities.
The CSHCN Advisory Board was formed in 2001 and has continued to function with a stable leadership and membership comprised of representatives from the public and private sectors and across social service and health care systems. In 2005, the advisory board agreed to work toward elevation to a mayoral commission. This year the board played an important role in implementing the access to care for children with epilepsy grant. In the next 5-year period, the Administration will continue to support the board and enlist it in advocacy for strengthening links across systems of care; however, the board has reached a place in its development where it is self-sustaining. Therefore, it is no longer a priority need for 2006-2010. See NP# 1 -- 6, 12, and SP# 7.

Population based: Strengthen universal newborn hearing screening and ensure the provision of follow up diagnostic, treatment and early intervention services.
In June 2000, the Administration recognized the need to expand newborn screening to include universal hearing screening. The award of a MCHB grant in 2001 enabled the Administration to implement hearing screening. Legislation mandating universal screening was enacted and most compliance issues have been resolved. Screening, follow-up testing and referrals to early intervention continued in 2005. With the structure is place, this is no longer a priority need for the period 2006-2010. See NP # 12 for current status and plans for ensuring follow up and enhancing early intervention.

Population-based: Work through health services delivery systems and neighborhood organizational infrastructure to reduce incidence of SIDS and other infant deaths.
After the recognition of this priority need in June 2000, the Administration dedicated 1 FTE to SIDS education. A curriculum on SIDS and back to sleep, consisting of a 15 minute power point presentation and a manual for community providers to use in a 90 minute session was developed. Educational sessions were presented to Healthy Start staff, other Administration employees and community partners and continue to be offered throughout the community. These sessions will continue to be offered beyond 2005.

The Administration will continue to integrate SIDS efforts into the operation of the Safe Cribs project so that families that receive crib vouchers also receive the back to sleep training. Nevertheless, the

number of deaths attributed to SIDS declined from 9 in 2000 to 0 in 2003. In addition to SIDS specific risk reduction efforts, much of the Administration's work is directed toward factors related to infant mortality, which continues to be a major concern to District public health officials. SIDS risk reduction education efforts will continue; however, this will no longer be an Administration priority. See NP # 1, 3, 13, 15, 18 and SP # 1, 2, 4, 5, 6.

Enabling services: Monitor and assess the effect of welfare repeal and mandatory managed care on health status.
Administration staff participated on various DOH task forces and committees to coordinate with and across Medicaid managed care organizations. In 2005, considerable progress was made in establishing MOUs with the Medicaid MCOs and establishing a structure for on-going conversations. The Administration will continue to work with sister agencies and community based organizations to improve services; however, the resources to monitor and assess the effects of welfare reform and managed care are not available. This is not a priority need for the period 2006 -2010. See NP# 1, 3, 4, 6, 7, 3, 12, 15, and SP# 1, 2, 3, 5, 7.

Continuing priorities:

1. Infrastructure development, population based services, and direct services: Assess needs and resources to improve oral health among children and youth.
Although Medicaid reimbursement rates were slightly adjusted in FY 2003, with another increase in the proposed FY 2006 budget, and increasing recognition of the lack of accessible services has resulted in mobile dental services offered in a few underserved neighborhoods, efforts have yet to result in observable improvements in access to and utilization of oral health services. In September 2002 the Administration secured funds from the Office of the Assistant Secretary for planning and Evaluation in the amount of $450,000 to implement a school-based oral health program that would restructure the manner in which oral health services are delivered to CSHCN enrolled in the public schools. Beginning with 2 schools dedicated to special needs children, the grant funds were applied in 2004 to renovate the medical/dental health suites and install telemedicine capabilities in order to serve the oral health needs of these students, many of whom have severe physical disabilities. Children were digitally linked to dentists at Children's National Medical Center who provided oral screenings, consultations, and referrals.

In the 3rd year, FY 2005, services were expanded to additional schools with large numbers of CSHCN. But the project has not progressed as planned, due to infrastructure deficiencies within the school system. It is anticipated that the approval of requested carry-over monies will be received for use in 2006.

The Healthy Start mobile medical unit, which is expected to be functioning by the beginning of FY 2006, will add oral health screening for pregnant and interconceptional women. In addition to beginning to build an oral health infrastructure by establishing an oral health division, located in the Administration's Adolescent and School Health Bureau, an Oral Health Coalition, consisting of organizations representing oral health and dental services providers, was formed in 2004. This priority will continue through 2010. See NP# 9 and SP# 2.

2. Enabling services: Reduce unintended pregnancies and teen births.
The Teen Mothers Take Charge (TMTC) program, originally funded by District TANF funds and later supported by Title V funds, originally provided monies to 4 community based organizations to provide care coordination and enrichment services to teen mothers with the objective of preventing unintended repeat pregnancies and assisting young mothers to become self sufficient. In FY 2005, due to budgetary reductions, the TMTC program provides services to 75 clients at 1 community based organization. The program is expected to continue through FY 2006, with an expected client load of 95 young women.

In June 2005, the 2 Healthy Start projects were refunded for a 4-year period with a focus to include perinatal and interconceptional care case management. The case managers support the clients in

avoiding unplanned repeat pregnancies within that time period. See also NP # 8, SP# 5, 7. This remains a priority for the period 2006-2010.

3. Infrastructure development and enabling services: Increase the proportion of the population that is insured, and increase the comprehensiveness of the coverage to include primary preventative services and preconceptional services.
MOUs were established with the 4 Medicaid MCOs in late 2004, opening the door for the development of standards care to improve services to the maternal and child health populations, including more comprehensive and accessible preconcenptional and interconceptional health care services.

The Administration has continued to disseminate information about Medicaid-SCHIP and the Alliance. See NP# 4, 13, 14 and SP# 2.

New Priorities 2006-2010

4. Infrastructure development, population-based, and enabling services: Increase awareness of the role of mental health in adolescent risk behaviors, school achievement and perinatal outcomes; and increase availability of preventive services.
Universal depression screening of Healthy Start clients will continue through June 2009, supported by 2 federal grants. A 1-year grant to expand perinatal depression screening in all areas of the city will be underway in FY 2006. The Administration will continue to work within an MOU with the DC Department of Mental Health to fund and co-locate 2 FTE licensed therapist positions at the Parent and Infant Development Program to receive, assess, diagnose and treat Healthy Start clients who screen positive for depression or other mental health problems.

The Administration will work with MCOs to incorporate more mental health services into physical care. This new priority is related to NP# 3, 5, 8, 16 and SP# 1, 5, 7.

5. Infrastructure development: Enhance nutrition and increase physical activity for children and youth.
In FY 2006, as WIC and related nutrition programs are integrated into the Administration, managers will schedule planning sessions in order that staff and managers are well informed about all programs, activities and objectives across bureaus. Integration into the Administration's structure presents the opportunity for staff to exploit all opportunities for coordination and integration, not only linkage of databases.

The Administration will continue to participate in the Obesity Prevention Advisory Council, which was convened in June 2005 by the Medical Assistance Administration (state Medicaid agency).

The recently re-funded Healthy Start grant includes a component to enlist clients in a post partum nutrition and physical activity program, partnering with the WIC Eat Smart/Move More program to establish sites specifically for Healthy Start participants.

In 2005, an Administrative staff member's time was allocated to coordinate with a local radio station, WPFW, campaign to establish "Movement Clubs" for persons between 40-70 years old. WPFW promotes the program through the Web site (www.wpfw.org), on-air announcements and public affairs programs. The Administration will assess the results to determine how best to support and/or expand this effort in 2006.

The Administration will also use its relationships with the public school system to understand and influence policies pertaining to vending machine access and contents, school and summer feeding programs, and school event sponsorships and fundraising. This priority may be somewhat related to NP# 11, SP# 1, O#6 and 09C.

6. Infrastructure development: Decrease violence toward children and youth.
Plans for FY 2006 include: establishment of a city-wide coalition for youth violence prevention that

consists of government, community and faith-based organizations; partnering to develop a youth violence prevention initiative for DC; and briefing city officials on the Department's stance and objectives relative to youth violence prevention in the District. Staff will seek funding opportunities to operationalize these plans.

The proposed realignment of the DOH includes the transfer of a violence prevention program (primarily focusing on sexual assault) to the Administration, increasing the opportunities for a more integrated violence prevention intervention strategy. Staff will be assisted to exploit opportunities to coordinate and integrate violence prevention programs. Efforts around this priority are expected to affect NP# 6, 8, 10 and O# 1, 2, 6.

7. Infrastructure development and direct services: Increase access to medical homes for CSHCN and support seamless systems of care and transitions across service systems.
Administration staff will continue to work to ensure that CSHCN services are well-integrated with Medicaid-SCHIP services. In Fiscal Year 2006, staff will work with Medicaid-SCHIP contractors and providers to adopt evidence-based standards of care for CSHCN, and support the training of staff in selected clinics to expand diagnostic and treatment skills for genetic disorders.

A large-scale effort (Medical Homes DC) under the leadership of the DC Primary Care Association is underway to increase the supply and capacity of community-based clinics to provide medical homes. Advocates for CSHCN have yet to be involved in these efforts. During FY 2006, Administration staff will attempt to coordinate their plans with those of the primary care "system".

Staff will continue to support the CSHCN Advisory Council in the identification of needs and opportunities for strengthening referral systems across systems of care. This priority is related to NP# 3, 4, 5, 6 and SP#3.

8. Infrastructure development: Increase the cultural competency of the MCH workforce and service organizations.
Along with follow up to the June 29-30, 2005 CAST-V analysis, the Administration will develop a plan to increase staff capabilities, including recruitment of persons with Spanish-English bicultural skills. Cultural and language competency standards will be incorporated into grants and contracts. And resources to assist with culturally competent and appealing print and video health education materials and public information campaigns will be identified and used. Administration staff will work with other DOH offices and administrations to increase the department's capacity to work with a variety of ethnic and language groups. The Administration will assist with documenting the unique needs of A/PI minorities and work with providers to accommodate those needs. The Administration will play a role in identifying and raising awareness of the needs of Latinos who are migrating to Wards 6, 7, and 8. This priority is related to NP# 2, 5, 11, 14 and SP#1.

9. Elimination of racial, ethnic, immigrant status and class disparities in birth outcomes and child health status.
The overarching priority delineated in 2000 will be carried over in the 2006-2010 period. This priority connects all 4 levels of services. Although a number of District health status measures show improvement, profound disparities continue to exist. Most of the national and District performance measures, in particular the outcome measures, are affected by disparities The Administration will continue to operate the grant-funded Healthy Start projects, which are designed to eliminate disparities in perinatal outcomes among African American women.

The state performance measures will remain the same as in the previous period.

## C. NATIONAL PERFORMANCE MEASURES

Performance Measure 01: *The percent of newborns who are screened and confirmed with condition(s) mandated by their State-sponsored newborn screening programs (e.g. phenylketonuria and hemoglobinopathies) who receive appropriate follow up as defined by their State.*

Tracking Performance Measures
*[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]*

| Annual Objective and Performance Data | 2000 | 2001 | 2002 | 2003 | 2004 |
|---|---|---|---|---|---|
| Annual Performance Objective | 100 | 100 | 100 | 100 | 100 |
| Annual Indicator | 99.2 | 100.0 | 100.0 | 100.0 | 100.0 |
| Numerator | 15035 | 14987 | 14578 | 14777 | 14830 |
| Denominator | 15156 | 14987 | 14578 | 14777 | 14830 |
| Is the Data Provisional or Final? | | | | Final | Provisional |
| | **2005** | **2006** | **2007** | **2008** | **2009** |
| Annual Performance Objective | 100 | 100 | 100 | 100 | 100 |

**Notes - 2003**

The 2003 number is provisional at this time since the 2003 birth file has not been reconciled for the year. There is a discrepancy of 154 births between the number of intial screens (14,777) and the unofficial 2003 birth occurences (14,623) for the Disttrict.

**Notes - 2004**

final data for 2004 has not been submitted. Information will be updated later.

## a. Last Year's Accomplishments

The newborn metabolic screening and follow-up continued as in previous years. The Mayor's Advisory Board on Metabolic Disorders was revived with new members. During 2004, the board supported the program's efforts to strengthen the District's newborn screening program and proposed expanding the current panel of disorders from 7 to 30, as recommended by the American College of Medical Genetics. Ihe board supported the Administration's effort to transfer payment of newborn screening testing to 3rd party payers, as stated in District law.

During the 2004 fiscal year, DOH officials sought to shift the cost of newborn metabolic screening from DC appropriated and Title V block grant funds to 3rd party insurance reimbursement. Management of the District's combined Medicaid/SCHIP program agreed to pay for its beneficiaries, although the Medicaid MCO contracts were not immediately readjusted to take into account an additional required service. The DC Hospital Association objected to this change in policy, saying that each hospital should do its lab work, making the contract for screening unnecessary. Beginning January 2004, the Administration paid for uninsured infants only. However, not all hospitals paid their lab bills, and discussions and negotiations among the lab contractor, DC Medicaid, DC Hospital Association and individual hospitals were on-going. Most of the District's hospitals agreed to make payments and worked with the laboratory to ensure that each child was screened at birth. Administration staff was confident that metabolic screening and follow up continued despite the problems surrounding responsibility to cover costs.

The sickle cell disease program continued providing health education sessions in the District of Columbia Public Schools (DCPS) and selected child care facilities. In FY 2004, 1308 students in 13 District schools participated in sickle cell health education sessions, an increase of over

100% from the previous year. The sessions were led by the staff coordinator who used art as a medium to teach children about the disease. Age and culturally appropriate presentation materials, such as a coloring book, give-away incentives and video, were used.

The Administration, through genetics service agreements with hospitals and community providers, provided payment for follow-up care for indigent and uninsured families. Staff completed the design of and distributed fact sheets on sickle cell intended to show prospective parents the probability of bearing a child with sickle cell disease under various scenarios and recommended testing to know one's status.

Efforts to use data from the newborn screening program as a central data source for linking administrative data sets for the DC Kids Link project, which is supported by the by the MFCB SSDI grant, continued. A 3-year grant for $100,000 annually for the period October 2003 through September 2006 was awarded to continue the development of DC Kids Link, a Web-based information system

**Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet**

| Activities | Pyramid Level of Service | | | |
|---|---|---|---|---|
| | DHC | ES | PBS | IB |
| 1. Develop and disseminate parent information materials | | X | X | |
| 2. Follow-up with positives to link with confirmatory testing, diagnosis, and services | | X | | |
| 3. Establish web-based and integrated reporting systems | | | | X |
| 4. Make available tertiary-level genetic services and counseling | X | | X | |
| 5. Disseminate sickle cell information and education to frontline to public school students | | | X | |
| 6. | | | | |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

## b. Current Activities

The Administration partnered with Howard University to submit an application to develop a well-coordinated intensive case management system and to establish a medical home for infants with sickle cell disease. The application received notice of funding on June 8, 2005.

The sickle cell project coordinator continues to work with Faces of Our Children, the National Organization for Wellness of Children and Families with Sickle Cell Disease, Inc. (NOW-CFSCD), SCANCA--a parents' support group, and Howard University Center for Sickle Cell Disease. She continues to present educational sessions in the public schools, encouraging students to obtain test results and to be aware if they carry the trait. Educational efforts in the public schools have revealed that many African American students are not knowledgeable about the disease, and because there is little support for public awareness campaigns, many believe the condition has been eradicated.

The coordinator contacts by telephone all families of infants identified with sickle cell disease and sickle cell trait to discuss the meaning of the test and to ensure that they are aware of follow-up services. Families are referred to the Administration's contractor Howard University

Center for Sickle Cell Disease for medical services.

The CSHCN Division continues to administer the newborn metabolic screening program. As in past years, unacceptable, inconclusive and positive test results are forwarded daily from the laboratory contractor to the CSHCN Division care coordinator. Families are notified by phone, and the care coordinator initiates follow-up activities. Families of children identified with sickle cell trait or G6PD are notified by mail (and telephone), with a letter from the DOH Chief Medical Officer and a fact sheet about the disorder.

The issue of responsibility for payment of laboratory services for metabolic screening continued to be debated with the advisory board playing a strong advocacy role. The DOH director agreed to convene a meeting in September 2005 with the Medicaid agency, the advisory board and hospital representatives. Although the laboratory services contractor reported $200,000 in arrears, the Medicaid agency had agreed to reimburse the hospitals for screening as part of the bundled newborn rate. Those hospitals with outstanding bills were asked to submit requests for Medicaid payment, and upon receipt of payment they were expected to pay the lab directly. To date, only 1 of the 7 hospitals continues to present a problem. The Administration has established a procedure for payment of screening fees for newborns that are not covered by another source of payment.

With the support of CSHCN Division management, the Mayor's Advisory Board on Metabolic Disorders recommended expansion of screening to cover 41 disorders. Under District law, the expansion can be accomplished by rule making, which the DOH legal counsel has initiated. A notice was placed in the DC register in September 2005.

## c. Plan for the Coming Year

The sickle cell education coordinator will serve as the project director for the grant recently received by Howard University to establish care coordination networks and medical homes for infants with sickle cell. The grant also has a research and an education component. Through the former, researchers hope to determine causes of the reported increase in the incidence of sickle cell trait. Education in the public schools will continue through contractual services.

Staff plans to meet with the Maryland CSHCN director early in the fiscal year to discuss issues about testing and follow-up, and payment for residents of one state born in a hospital located in the other state, an issue that has been observed for a number of years but has yet to be resolved.

Work on the final year of the SSDI grant to develop an integrated child health record system that utilizes newborn screening data as the central source will be completed as described above.

Once the metabolic screening payment issues are completely resolved, staff will begin to plan for the implementation of the expansion of the newborn metabolic screening to 41 disorders. Issues to be considered include: gaining cooperation from the Medicaid agency and hospitals; estimating costs and negotiating with the lab contractor; determining implications for increased staffing needs; adapting and developing informational materials for families (This is underway.); working with the March of Dimes to conduct grand rounds in hospitals; and training hospital staffs.

CSHCN Division, Genetics Services Branch staff will continue work started in FY 2005 with the DOH Office of Information Technology, DC Linkage and Tracking System, the DC Lead Tracking Program, the Medicaid agency and the immunization registry, all of which share some components of a child health record. Final year and carry over SSDI grant funds for the DC Kids Link project will be applied to the support of an integrated child health record. This Web

based health information system is intended to link newborn metabolic screening results with newborn hearing screening results, vital records, lead screening information, Medicaid and possibly other District agency administrative databases

Performance Measure 02: *The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)*

Tracking Performance Measures
*[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]*

| Annual Objective and Performance Data | 2000 | 2001 | 2002 | 2003 | 2004 |
|---|---|---|---|---|---|
| Annual Performance Objective | | | | 56 | 56.5 |
| Annual Indicator | | | 55.5 | 55.5 | 55.5 |
| Numerator | | | | | |
| Denominator | | | | | |
| Is the Data Provisional or Final? | | | | Final | Final |
| | **2005** | **2006** | **2007** | **2008** | **2009** |
| Annual Performance Objective | 57 | 57.5 | 58 | 58 | 58 |

**Notes - 2002**

The 2002 indicator is based on the State estimates from SLAITS.

**Notes - 2003**

The data reported in 2002 have pre-populated the data for 2003 for this performance measure.

**Notes - 2004**

The data reported in 2004 are pre-populated with the data from 2003 for this performance measure. Data taken from 2001 SLAITS CSHCN Survey.

a. Last Year's Accomplishments

Several parents continued to participate in monthly meetings of the CSHCN Advisory Board.

The CSHCN Division continued efforts to establish a parent-run information and education resource center and drop-in facility; however, grant writing to obtain dedicated funding was not successful. Space was obtained at the same building at which the division staff was located and furniture and equipment were purchased; computers were contributed by a similar project at Children's National Medical Center. Without dedicated funding and staff, efforts to organize the DC Special Needs Family Network to reach out to families with special needs children to provide information and education, support, referral and coordination did not progress.

**Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet**

| | **Pyramid Level of** |
|---|---|

| Activities | Service | | | |
|---|---|---|---|---|
| | DHC | ES | PBS | IB |
| 1. Continue to participate in medical home collaborative | | | | X |
| 2. Provide education and information to parents of CSHCN. | | X | | |
| 3. Parent participation on advisory boards | | | | X |
| 4. | | | | |
| 5. | | | | |
| 6. | | | | |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

## b. Current Activities

CSHCN staff continues to work on recruiting, retaining and supporting family participation in the advisory board. The board formed a medical affairs committee, which is playing a strong advocacy role. Physician members met in February 2005 with the DOH director to request improved reimbursement rates and better services for children.

The Administration was awarded an MCHB grant to improve services for children with epilepsy. Grant funds are being used to enable the Medicaid MCOs to hire parent advocates to inform, educate and engage parents in service delivery. Each MCO has a parent advisory group that will also be involved in grant-related activities.

It became evident that resources were not available to proceed with development of the parents' resource center, and then the DOH decided to move the CSHCN Division from its current location (which had space for the resource center) back to the central DOH offices. Staff became aware that several private organizations (Children's National Medical Center, Kennedy Institute, Health Services for Children Foundation) had or were developing similar resource centers and decided to work with and support these organizations rather than set up another center. Discussions are underway with Children's National Medical Center for the transfer of furniture and equipment to a satellite clinic in the southeast quadrant to establish a resource center in an underserved community.

Parents of CSHCN were among those stakeholders represented in focus groups convened for the development of the Title V 5-year needs assessment.

Marilyn Seabrooks Myrdal, Maternal and Child Health Officer, was elected to the Association of Maternal and Child Program (AMCHP) Board of Directors and represents Region III Title V directors on the Family Leadership Caucus. The Caucus is charged by AMCHP's leadership in crafting a cooperative strategy for ensuring greater involvement of parents at the state and national levels. Ms. Seabrooks has been instrumental in helping the Caucus to design a strategy that serves to impact the Association's strategic planning process to involve parents in the work of AMCHP as well as states and territories. Key components include the designation of family member as delegates to AMCHP, the hiring of family members within state structures and covering the costs of family delegates to attend AMCHP's annual conference.

## c. Plan for the Coming Year

CSHCN staff will continue to recruit and support parents to participate in the CSHCN Advisory Board.

Implementation of the epilepsy grant will continue.

Staff will also coordinate an application in response to an expected RFA for parent resource centers. However, they will encourage a private sector organization to be the recipient of the grant and to be responsible for operating the center. Staff will work with the organizations mentioned above as well as the DC chapter of Family Voice and a center in Prince George's Maryland to coordinate the exchange of resources.

Performance Measure 03: *The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)*

Tracking Performance Measures
*[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]*

| Annual Objective and Performance Data | 2000 | 2001 | 2002 | 2003 | 2004 |
|---|---|---|---|---|---|
| Annual Performance Objective | | | | 42 | 42.5 |
| Annual Indicator | | | 41.4 | 41.4 | 41.4 |
| Numerator | | | | | |
| Denominator | | | | | |
| Is the Data Provisional or Final? | | | | Final | Final |
| | **2005** | **2006** | **2007** | **2008** | **2009** |
| Annual Performance Objective | 43 | 43.5 | 44 | 44 | 44 |

**Notes - 2002**

The 2002 indicator is based on the State estimates from SLAITS.

**Notes - 2003**

The data reported in 2002 have pre-populated the data for 2003 for this performance measure.

**Notes - 2004**

The data reported in 2004 are pre-populated with the data from 2003 for this performance measure. Data taken from 2001 CSHCN SLAITS Survey.

a. Last Year's Accomplishments

The medical home concept continued to be integrated into newborn hearing and metabolic screening, asthma prevention and control, birth defects registry, and genetic services. Each of these projects had as a component to work with families to establish a medial home for the infant.

In 2004, contracts with Howard University Hospital and George Washington Medical Center were finalized. Howard University Hospital provided sickle cell and other pediatric services, and George Washington University Medical Faculty Associates provided prenatal genetic services. Unlike past years when the services were made available in conjunction with community health

centers, these services were hospital based. It was decided not to pursue the planned contract with Georgetown University to provide training on medical homes for CSHCN.

Helping to ensure that newborns were linked to pediatric services was one of the purposes of the hospital-based discharge planning for newborns, described in section E Other Program Activities. For many infants this was the initial step in the establishment of a medical home.

**Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet**

| Activities | Pyramid Level of Service | | | |
|---|---|---|---|---|
| | DHC | ES | PBS | IB |
| 1. Present provider training conference on medical home | | | | X |
| 2. Newborn discharge planning | | X | | |
| 3. Participate in medical home collaborative | | | | X |
| 4. | | | | |
| 5. | | | | |
| 6. | | | | |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

b. Current Activities

In January 2005 the District was accepted as one of the 10 participating states in the Medical Home Learning Collaborative, a 15-month project committed to helping primary care practices become accessible and family-centered, and to provide care that is continuous, comprehensive, coordinated, compassionate, and culturally effective. A particular emphasis is placed on care coordination and family involvement in decision-making for CSHCN. Administration staff recruited 3 teams, 2 based at Children's National Medical Center and 1 at Hospital for Sick Children, as partners in the program. In February 2005, 12 team members received training.

The primary care practices each form an improvement team that minimally includes a physician, a parent partner, and one other key health professional employed at he practice. They also agree to attend the 3 major learning sessions, to meet at least monthly as an improvement team, and to collect data over a 1-year period. The Title V agency also must create an improvement team consisting minimally of a Title V agency representative, a parent partner, a Medicaid or other insurance representative, and an American Academy of Pediatric (AAP) representative. As of September 2005, 1 team is continuing to participate. 1 team found the data collection requirements too onerous; another team became discouraged with IRB requirements. However, the remaining team and the other representatives are continuing to participate in conference calls and other learning activities.

Instead of contracting with Georgetown Hospital (see 2004 activities), a contract was negotiated with the Genetic Alliance to develop a genetics training manual to train health care service providers, such as nutritionists, health educators, substance abuse counselors, therapists, RNs, PAs and other health professionals, to understand genetics and genetic conditions and to make appropriate referrals. The contract includes revisions of the March of Dimes manual of genetic conditions to make it more applicable to the District's population and service delivery system. The manual will then be distributed to health care providers throughout

the District and an online training course will be developed to strengthen this educational effort.

Hospital based discharge planning continues. The Administration provides funding for an MSW or RN in 5 of the District's 7 birthing hospitals. The discharge planner conducts an assessment interview with the new mother and encourages her to schedule a home visit by an RN--provided by the patient's Medicaid MCO, one of the Healthy Start projects located in the District, or another Administration employee. In addition to assistance and referrals offered during the initial hospital interview, the home visit may result in additional referrals to social services and follow-up with care coordination.

### c. Plan for the Coming Year

Staff will continue to participate in the Medical Home Learning Collaborative II (MHLC II), sponsored by the National Initiative for Children's Healthcare Quality (NICHQ). Staff will work with the local chapter of the AAP to apply for a CATCH grant to support training of members in medical homes.

The Medicaid agency has agreed to include in the MCO contracts a requirement for on-going screening to identify possible CSHCN. Administration staff will continue to meet with MCO representatives to discuss implementation of the requirement.

Depending on whether there are sufficient funds remaining in the contract with Genetic Alliance, staff may need to conduct the genetic services training for selected providers, such as the Unity Health Care (330 grantee) clinics.

The Administration will continue to support a range of genetic services, including educational efforts to inform families of the availability of services.

The Administration will complete an assessment of the results to date of the newborn discharge planning and determine what, if any, modifications should be made.

## Performance Measure 04: *The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)*

Tracking Performance Measures
*[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]*

| Annual Objective and Performance Data | 2000 | 2001 | 2002 | 2003 | 2004 |
|---|---|---|---|---|---|
| Annual Performance Objective | | | | 60.5 | 61 |
| Annual Indicator | | | 55.9 | 55.9 | 55.9 |
| Numerator | | | | | |
| Denominator | | | | | |
| Is the Data Provisional or Final? | | | | Final | Final |

| | 2005 | 2006 | 2007 | 2008 | 2009 |
|---|---|---|---|---|---|
| Annual Performance Objective | 61.5 | 62 | 62.5 | 62.5 | 63 |

**Notes - 2002**

The 2002 indicator is based on the State estimates from SLAITS.

**Notes - 2003**

The data reported in 2002 have pre-populated the data for 2003 for this performance measure.

**Notes - 2004**

The data reported in 2004 are pre-populated with the data from 2003 for this performance measure. Data taken from 2001 CSHCN SLAITS Survey.

## a. Last Year's Accomplishments

The Administration actively informed families with CSHCN of eligibility criteria and the procedures for applying for Medicaid-SCHIP benefits. Information was disseminated via the 800 HEALTLINE, neighborhood health fairs, and outreach supported by categorical grant-funded programs. (See NP# 13.) The Administration staff worked with the CSHCN Advisory Board to clarify and expand the services available to those Medicaid-SCHIP CSHCN beneficiaries who received services through the MCOs. Unlike those children who were both Medicaid and SSI recipients and had access to expanded services through a dedicated MCO, the services needed by many special needs children were sometimes difficult to obtain.

Infants with positive metabolic or hearing screens were assisted with Medicaid-SCHIP enrollment if they appeared to be eligible and were not already receiving services. If they were enrolled, staff worked with the families to ensure that they received services.

A vision screening program operated in conjunction with Lion's Club volunteers assisted many children to receive screening and diagnostic vision services, as well as to be fitted with glasses, services that were not covered or readily accessible from their insurance provider.

A HRSA grant for newborn hearing screening helped to provide hearing aids and other devices through a loaner's bank for several privately insured infants as well as fee-for-service Medicaid beneficiaries, such as children in foster care, who could not easily obtain these devices.

**Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet**

| Activities | Pyramid Level of Service | | | |
|---|---|---|---|---|
| | DHC | ES | PBS | IB |
| 1. Identify gaps in coverage for vision and hearing aids and advocate to close gaps | | | | X |
| 2. Enlist advisory board in advocacy for Medicaid-SCHIP services | | | | X |
| 3. Continue HEALTHLINE and other information dissemination | | X | X | |
| 4. Participate in meetings with Medicaid MCOs. | | | | X |
| 5. | | | | |
| 6. | | | | |
| 7. | | | | |
| 8. | | | | |
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b. Current Activities

The CSHCN Advisory Board formed a medical affairs committee that made recommendations to and met with the DOH director concerning expanding services to CSHCN.

The Administration is continuing efforts through the newborn screening programs to assist families in enrolling children in Medicaid-SCHIP.

By December 2004 the 3 MCOs and the CSHCN carve-out MCO had signed MOUs outlining the respective responsibilities of the MCO, MAA and the Administration. The agreements focus on the care coordination and continuity of care for those MCO enrollees who are also Administration clients, including CSHCN. Beginning in January 2005, a representative from the CSHCN Division and other Administration staff held monthly meetings with Medicaid agency staff and MCOs representatives. To date, the meetings have been primarily focused on sharing information about programs, services and barriers.

c. Plan for the Coming Year

The Administration will continue to work through the CSHCN Advisory Board and with the Medicaid MCOs to increase awareness of and attention to the needs for additional services for all CSHCN. It is expected that in FY 2006, staff and MCOs and Medicaid representatives will begin work on case management standards and protocols

Staff will continue to identify eligible CSHCN and assist them in obtaining public health insurance.

Performance Measure 05: *Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)*

Tracking Performance Measures
*[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]*

| **Annual Objective and Performance Data** | **2000** | **2001** | **2002** | **2003** | **2004** |
|---|---|---|---|---|---|
| Annual Performance Objective | | | | 71 | 71.5 |
| Annual Indicator | | | 69.9 | 69.9 | 69.9 |
| Numerator | | | | | |
| Denominator | | | | | |
| Is the Data Provisional or Final? | | | | Final | Final |
| | **2005** | **2006** | **2007** | **2008** | **2009** |
| Annual Performance Objective | 72 | 72.5 | 73 | 73 | 73 |

**Notes - 2002**

The 2002 indicator is based on the State estimates from SLAITS.

**Notes - 2003**

The data reported in 2002 have pre-populated the data for 2003 for this performance measure.

**Notes - 2004**

The data reported in 2004 are pre-populated with the data from 2003 for this performance measure. Data taken from 2001 CSHCN SLAITS Survey.

## a. Last Year's Accomplishments

Work commenced on the early childhood comprehensive systems grant when budget authority was received February 2004. The scope of the target population was expanded to include the prenatal period through age 8. Staff worked with the Mayor's Committee on Early Childhood Development and the Office of Early Childhood Development on implementation. Grant activities were coordinated with 2 related Department of Human Services grant efforts--SPARKS and Early Learning Opportunities Act grant (ELOA). A workshop presentation on the vision and activities was conducted at the annual maternal and child health conference in February 2004. Braintree Solution Consulting produced a systems map of the District's early childhood system.

**Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet**

| Activities | Pyramid Level of Service | | | |
|---|---|---|---|---|
| | DHC | ES | PBS | IB |
| 1. Complete systems planning grant | | | | X |
| 2. | | | | |
| 3. | | | | |
| 4. | | | | |
| 5. | | | | |
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## b. Current Activities

Work is continuing on the early childhood comprehensive systems grant. Braintree Solution Consulting is working on a more detailed mapping of resources, funding, program capacity, and outcome tracking. The mapping is expected to articulate the relationship between federal and DC resources and to promote greater efficiency and effectiveness of program and financial management, and finally a plan for systems integration. The grant has been renewed for a 4-year period, beginning September 2005.

## c. Plan for the Coming Year

Staff will continue to work with partners on the early childhood comprehensive systems grant. We expect to complete resource mapping and other activities to agree on a strategic plan, and to move into the implementation phase during the fiscal year.

Performance Measure 06: *The percentage of youth with special health care needs who received the services necessary to make transition to all aspects of adult life. (CSHCN Survey)*

Tracking Performance Measures
*[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]*

| Annual Objective and Performance Data | 2000 | 2001 | 2002 | 2003 | 2004 |
|---|---|---|---|---|---|
| Annual Performance Objective | | | | 6.5 | 7 |
| Annual Indicator | | | 5.8 | 5.8 | 5.8 |
| Numerator | | | | | |
| Denominator | | | | | |
| Is the Data Provisional or Final? | | | | Final | Final |
| | **2005** | **2006** | **2007** | **2008** | **2009** |
| Annual Performance Objective | 5.8 | 8 | 8.5 | 9 | 9 |

**Notes - 2002**

Because only one of the States (Maine) met the NCHS standards for reliability for PM 6, the 2002 indicator is the national average except for Maine which has its State value noted.

**Notes - 2003**

The data reported in 2002 have pre-populated the data for 2003 for this performance measure.

**Notes - 2004**

The data reported in 2004 are pre-populated with the data from 2003 for this performance measure. Data taken from 2001 CSHCN SLAITS Survey.

## a. Last Year's Accomplishments

The Administration participated in an Interagency Transition Workgroup, which included representatives from DC Public Schools, vocational counselors from the Rehabilitation Service Administration, Marriott Bridges, Internal Revenue Service, Medicaid, and Mental Retardation Developmental Disability Administration among others. Staff worked with employees at the Mamie D. Lee School and Sharpe Health School around transition of students to adult medical homes.

**Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet**

| Activities | Pyramid Level of Service | | | |
|---|---|---|---|---|
| | **DHC** | **ES** | **PBS** | **IB** |
| 1. Continue to work with Woodson students on transition readiness skills | **X** | | | **X** |
| 2. | | | | |
| 3. | | | | |
| 4. | | | | |
| 5. | | | | |

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| 6. | | | | |
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### b. Current Activities

The DCPC reduced the number of transition coordinator positions and the Administration did not have the resources to dedicate a position for transition efforts. Nevertheless, the sickle call coordinator was able to obtain an intern to initiate several activities. The CSHCN Division started a pilot project for transitional services at Woodson High School to provide adolescents with sickle cell disease with community resources to support skill building, independent living and transition from pediatric to adult health care. Students are receiving information that will help them manage their own healthcare and use adult health passports to keep track of appointments, family history, medications, allergies and other health related information. Woodson High School is the site of a Healthy Start grant-funded wellness center, and the social worker and pediatric nurse practitioner identified and recruited students, and offered individual and group educational and counseling sessions.

### c. Plan for the Coming Year

The CSHCN Division will continue to seek grant funding for staff to work on transitional infrastructure building. The project at Woodson Senior High School will continue as described above. Depending upon resources, the project may be expanded to teens in other high schools and also to teens participating in the Children's National Medical Center Family-to-Family Program.

Performance Measure 07: *Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.*

Tracking Performance Measures
*[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]*

| Annual Objective and Performance Data | 2000 | 2001 | 2002 | 2003 | 2004 |
|---|---|---|---|---|---|
| Annual Performance Objective | 75 | 75 | 79 | 82 | 85 |
| Annual Indicator | 67.8 | 68 | 68.7 | 66.2 | 82 |
| Numerator | | | | | |
| Denominator | | | | | |
| Is the Data Provisional or Final? | | | | Final | Final |
| | **2005** | **2006** | **2007** | **2008** | **2009** |
| Annual Performance | 70 | 70 | 72 | 72 | 75 |

| Objective | | | | | |
|---|---|---|---|---|---|

**Notes - 2002**

2002 estimate is based upon National Immunization Survey. CIs +/- 7.5
Children in the Q3/2001-Q2/2002 National Immunization Survey were born between August 1998 and November 2000. 4:3:1:3:3 series.
http://www.cdc.gov/nip/coverage/NIS/01-02/TAB29-43133_race_iap.htm
Previous years' indicators were for different series, and for 2001 children under 24 months.

**Notes - 2003**

2003 estimate is based upon National Immunization Survey, 4:3:1:3:3 series. CIs +/-8.5, Estimated Vaccination Coverage with Individual Vaccines and Selected Vaccination Series By 24 Months of Age by State and Immunization Action Plan Area -- US, National Immunization Survey, Q3/2002-Q2/2003. Children in the Q3/2002-Q2/2003 National Immunization Survey were born between August 1999 and November 2001.
http://www2a.cdc.gov/nip/coverage/nis/nis_iap.asp?fmt=v&rpt=tab09_24mo_iap&qtr=Q3/2002-Q2/2003

**Notes - 2004**

2004 estimate is based upon National Immunization Survey, 4:3:1:3:3 series. CIs +/-5.7, Estimated Vaccination Coverage with Individual Vaccines and Selected Vaccination Series By 24 Months of Age by State and Immunization Action Plan Area -- US, National Immunization Survey, Q3/2003-Q2/2004. Children in the Q3/2003-Q2/2004 National Immunization Survey were born between February 2001 and May 2003.
http://www.cdc.gov/nip/coverage/nis/04/tab03_antigen_state.xls

## a. Last Year's Accomplishments

General information about immunizations was available to the public through the 800 HEALTHLINE. The information and referral HEALTHLINE was staffed 8:00 AM to 8:00 PM, Monday through Friday, and took voice messages during other hours. Among other types of information and referral requests, staff responded to queries about immunization schedules and disseminated information on the availability of express and community clinics where immunizations could be obtained.

Title V funds were used to provide partial support for a public information campaign, conducted by DOH and DCPS, to promote compliance with immunization requirements for school admission.

Care coordination for Healthy Start and Teen Mothers Take Charge clients and their infants continued to inform and educate clients on the importance of adhering to immunization schedules, made appointments and arrangements for immunization as necessary and tracked compliance. Both programs followed infants to at least age 2.

**Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet**

| Activities | Pyramid Level of Service | | | |
|---|---|---|---|---|
| | DHC | ES | PBS | IB |
| 1. Participate in school nurse immunization committee and integration of records | | | | X |
| 2. Redeploy staff for school immunization campaigns | | | X | |
| 3. Counsel and follow-up on client immunization status (Healthy Start and Teen Mothers Take Charge) | | X | | |

| | | | | |
|---|---|---|---|---|
| 4. Continue providing information on immunization on HEALTHLINE | | | X | |
| 5. Participate in public information campaign. | | | | X |
| 6. | | | | |
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| 10. | | | | |

### b. Current Activities

Compliance with immunization schedules continues to be an essential component of the care coordination provided to infants through the Healthy Start and Teen Mothers Take Charge projects.

The Administration adolescent health officer continues to participate in the Immunization Task Force convened by public school system officials and Children's National Medical Center. Staff continues to be deployed as necessary to respond to needs to staff express clinics prior to the start of school. Information dissemination is continuing through the DOH information and referral telephone number.

Title V funds are being used to provide partial support for a public information campaign, conducted by DOH and DCPS, to promote compliance with immunization requirements for school admission.

### c. Plan for the Coming Year

Care coordination provided through the Healthy Start and Teen Mothers Take Charge projects will continue to include monitoring on infants' immunization status, educating mothers on the importance of compliance with immunization schedules, and arranging for appointments with providers. As described elsewhere in this application, the Teen Mothers Take Charge project reduced funding to 1 organization.

Information on immunization will be made available to the public through the DOH central information number. Title V funds will provide partial support for a public information campaign, conducted by DOH and DCPS, to promote compliance with immunization requirements for school admission.

## Performance Measure 08: *The rate of birth (per 1,000) for teenagers aged 15 through 17 years.*

Tracking Performance Measures
*[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]*

| Annual Objective and Performance Data | 2000 | 2001 | 2002 | 2003 | 2004 |
|---|---|---|---|---|---|
| Annual Performance Objective | 54.3 | 49.5 | 45.1 | 41.1 | 37.4 |
| Annual Indicator | 53.3 | 45.4 | 46.5 | 39.7 | 39 |
| Numerator | 408 | 346 | 348 | 293 | |
| | | | | | |

| | | | | | |
|---|---|---|---|---|---|
| Denominator | 7657 | 7621 | 7487 | 7384 | |
| Is the Data Provisional or Final? | | | | Final | Provisional |
| | **2005** | **2006** | **2007** | **2008** | **2009** |
| Annual Performance Objective | 34.1 | 34.1 | 34.1 | 32 | 32 |

**Notes - 2002**

2001 is the most recent available data for the District. There is a two year lag time for vital records information.

**Notes - 2003**

In 2003 there were 7616 births. The denominator does not include 232 cases that were missing maternal age.

**Notes - 2004**

2003 is the most recent available year for data.

## a. Last Year's Accomplishments

The Adolescent Health Division expanded its services to offer a variety of modules from the abstinence-based "I'm Worth the Wait" curriculum, which targeted ages 8-12 years. The curriculum, which has been utilized for several years, has been supplemented with other activities developed by staff. The curriculum was user-friendly, interactive and informative. Each module consisted of age-appropriate questions that assessed the level of knowledge of the group.

During FY 2004, 2 health educators supported by the abstinence grant continued to work with community and faith-based organizations and schools to deliver units of the "I'm Worth the Wait" curriculum. As in prior years, a health educator met weekly with 2 3rd grade classes. Peer education using the 12 member Shaed Players troupe continued.

A research protocol for a longitudinal evaluation study was resubmitted and approved by the DOH Institutional Review Board. The study will compare outcomes of children that complete the "I'm Worth the Wait" program with a comparison group. The Data Collection and Analysis Division will be responsible for carrying out the sampling and data collection.

The abstinence education project director continued to represent the Administration with the DC Campaign to Reduce Teen Pregnancy. She worked with Media Education Entertainment on identifying targets and developing messages consistent with the Campaign's objectives.

**Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet**

| **Activities** | **Pyramid Level of Service** | | | |
|---|---|---|---|---|
| | **DHC** | **ES** | **PBS** | **IB** |
| 1. Implement "I'm Worth the Wait" abstinent education curriculum | | **X** | | |
| 2. Fund "Teen Mothers Take Charge" services, case management including family planning | | **X** | | |
| 3. Participate in DC Campaign to Prevent Teen Pregnancy | | | **X** | **X** |
| 4. | | | | |
| 5. | | | | |

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|---|---|---|---|---|
| 6. | | | | |
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## b. Current Activities

The Administration proceeded with efforts to develop a health and sexuality education curriculum that could be delivered by youth services providers. The health and sexuality education coordinator recruited 12 students (including 2 special education students) from Woodson Senior High School to form an on-going peer performers' troupe, similar to the Shaed Players. A health and sexuality education curriculum, consisting of elements of SMART START and Let's Talk About Sex Baby, was presented. The students were retained throughout the summer in the summer youth employment program, and efforts are being made to continue their employment during the school year. During the summer the youth developed a health and sex education performance, which they presented to their peers in a number of venues.

The health and sexuality education coordinator worked with the Children and Family Services Administration to present an overview of youth health and sexuality to 3 groups of foster parents, totaling 135. 40 group home directors were oriented as well.

Staff is working to obtain an MOU with the DC Public Schools to approve the longitudinal evaluation study comparing outcomes of children that complete the "I'm Worth the Wait" program with a comparison group. The longitudinal study originally included 25 students in 4th - 6th grades, from each of 9 transformation schools; the study is now planned for 1 study school and a comparison school.

Staff continues to meet with DC Public Schools staff regarding the need to establish a health and sexuality curriculum in the schools. A review of available curricula has yet to be undertaken.

The health and sexuality education coordinator established a youth advisory group, consisting of 12 students based at McKinley High School. The group is serving as "ambassadors" for DOH, reviewing grants that pertain to youth services, and commenting on educational, informational and/or social marketing efforts directed toward the youth population.

20 new students were recruited for a peer educator theatre troupe of 4th - 6th graders. The Shaed Players continue to be a component of the program. Peer educators and members of the theatre troupe function as role models and acquire knowledge and skills enabling them to present information that is expected to lead to positive decision making for themselves and their peers. The theatre group was trained in preparation for presentations to occur next year.

The bilingual (Spanish-English) abstinence educator continues to work in conjunction with a school, a church and 2 community-based organizations, all serving a primarily Latino population, to train trainers and to deliver the Spanish version of "I'm Worth the Wait."

See the description of Teen Mothers Take Charge, SP # 7, which may also contribute to a decrease in teen birth rates.

## c. Plan for the Coming Year

The Administration will continue to administer the abstinence education grant with expected increased federal funding. Activities described above will continue. Technical assistance to Latino organizations will be expanded, resulting in an increase in the number of Latino youth

who have completed units of the abstinence curriculum. Teen Mothers Take Charge will continue as well.

Work with students at Woodson Senior High School in the development of the health and sexuality education curriculum will continue.

Performance Measure 09: *Percent of third grade children who have received protective sealants on at least one permanent molar tooth.*

Tracking Performance Measures
*[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]*

| Annual Objective and Performance Data | 2000 | 2001 | 2002 | 2003 | 2004 |
|---|---|---|---|---|---|
| Annual Performance Objective | 14 | 15 | 50 | 55 | 60 |
| Annual Indicator | 10.0 | 10.0 | 10.0 | 10.0 | 10 |
| Numerator | 744 | 744 | 744 | 744 | |
| Denominator | 7437 | 7437 | 7437 | 7437 | |
| Is the Data Provisional or Final? | | | | Provisional | Provisional |
| | **2005** | **2006** | **2007** | **2008** | **2009** |
| Annual Performance Objective | 65 | 67 | 69 | 69 | 69 |

**Notes - 2002**

NEED TO ADD NOTE

**Notes - 2003**

Data provided for this measure is an estimate. One of the goals of the District's SSDI grant obtain accurate information for this performance measure by conducting a oral health visual screening needs assessment of a sample of third grade students.

**Notes - 2004**

Data provided for this measure is an estimate.

a. Last Year's Accomplishments

On June 21, 2004, a motion was filed on behalf of the plaintiffs to enforce the Salazar Settlement Order to make the District take more concrete steps to improve dental health under EPSDT. The filing used the 416 reports to document that utilization of dental services has declined. The plaintiffs also documented that reimbursement rates are below the 25th percentile for the South Atlantic region. Additionally, evidence was presented that the supply of dentists was inadequate in underserved areas, as well as the number of dentists on the MCOs lists of providers.

Also in FY 2004, the DOH began a pilot school-based sealant project. Using remaining funds from the Community Voice Kellogg Foundation grant, DOH purchased portable equipment and retained a dentist and hygienist to do examinations, cleanings and to apply sealants. 7

elementary schools were identified based on high need and a cooperative school administration. The number of 2nd and 3rd graders in the 7 schools totaled 827; 49% returned consent forms and were subsequently given an oral exam, prophylaxis (dental cleaning) and fluoride treatment. The percent of children participating varied from 29% to 92%.

Of the 406 children examined, 50% had decayed primary teeth and 19% had decayed permanent teeth. They were referred to their managed care provider or to an area clinic that accepts Medicaid payments. The extent to which these children were able to obtain treatment is not known. Only 12% had sealants. Sealants were provided to 72% (260/359) of children without sealants. In total 988 sealants were placed.

In conjunction with the oral health integrated systems development grant, in May 2004, DOH received approval from DC Public Schools, on behalf of Children's National Medical Center (CNMC), to install telemedicine equipment at Sharpe Health and Mamie D. Lee schools as well as authorization to continue wire extensions to the dental clinic at Sharpe to facilitate the use of telemedicine.

Between October 1, 2003 and September 30, 2004, CNMC had a total of 387 encounters at Sharpe, Mamie D. Lee, Taft and Prospect schools, including 151 cleanings, 97 sealants and filings, 234 in-office consultations, 15 outside referrals with 9 resolved.

**Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet**

| Activities | Pyramid Level of Service | | | |
|---|---|---|---|---|
| | DHC | ES | PBS | IB |
| 1. Continue to support the Oral Health Coalition | | | | X |
| 2. Integrate the Oral Health Division into Acministration activities | | X | | |
| 3. Continue to seek resources for school based sealant pilot | X | | | |
| 4. Complete oral health integrated system development activities | X | | | X |
| 5. | | | | |
| 6. | | | | |
| 7. | | | | |
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| 10. | | | | |

## b. Current Activities

The Administration's plan, described in the 2001 application, to support a physical examination survey to develop estimates of oral health status and morbidity has yet to be implemented. Since the inception of the TVIS, the District has been unable to provide an estimate of the prevalence of sealants. Planning and development of an oral health needs assessment has continued for 3 years, with the expected use of a survey approach based on a methodology used by the state of New Hampshire in its oral health survey of 3rd grade students in 2001. A brief non-invasive dental screening was to have been conducted on each child. Using a mouth mirror and tongue depressor each child was to have been checked for sealants, and for filled and/or decayed teeth. The urgency of need for treatment was to have been recorded along with the information on sealants and caries experience.

An MOU developed between the DOH, Howard University College of Dentistry (HUCD), and the District of Columbia Public Schools (DCPS), had to be revised to exclude HUCD as part of

new DOH guidelines. Training dates for survey staff and volunteers and participating school sites and dates will be finalized upon completion of the new MOU and approval by all the partners. Because the process for obtaining an agreed upon MOU has been arduous, staff began to look at alternative ways of measuring NP #9.

The grant from the Office of the Assistant Secretary for Policy, Planning and Evaluation, which was described in previous applications, is in the final year. The grant supports deployment of the mobile van unit to Taft and Prospect schools. Staffing capacity for the project was increased and now includes 1.5 dentists, 1 dental assistant, 1 referral coordinator, a telemedicine manager- coordinator- and technician, DOH program coordinator, CNMC program manager, and 2 positions at CNMC providing project oversight for telemedicine consults and clinical procedures.

The experience with the school based sealant project to-date confirms that there is a considerable unmet need/demand for both preventive and restorative dental services among public school children, a need that can be met only in part by a school-based program.

The Department of Health continued to pilot a school-based sealant program for 2nd and 3rd graders in 4 schools in underserved areas. Of a total of 483 students, 55% returned consent forms and nearly all of those with consent were examined. The results of the examination indicate the level of need. 63% of children examined had decayed primary teeth, 19% decayed permanent teeth. Only 15.5% of the children examined had sealants. There was considerable variation in the prevalence of sealants across the 4 schools--from 7 to 40%. Sealants were placed on 93% of the children without them, a total of 830 sealants. The continuation of the program is dependent upon resources. The director is also working with an Oral Health Coalition.

See SP# 3 (EPSDT) for status of Salazar compliance.

### c. Plan for the Coming Year

Under the planned FY 2006 restructuring of the Maternal and Family Health Administration, the school-based dental sealant program will be placed in the oral health division of the Adolescent and School Health Bureau. The division's dentist has agreed to provide data on screening and sealant results from the program including age of child, grade in school, number of caries, sealants and other oral health issues. If the MOU between DCPS and the DOH is not signed and implemented by November 2005, the Administration will rely on data from the school-based dental sealant program to provide an estimate for this performance measure.

The Children's National Medical Center mobile dental unit will expand services to additional schools. The Administration is currently considering whether to continue direct subsidy of the dental services at Mamie D. Lee and Sharpe schools and is encouraging DCPS and CNMC to maximize Medicaid reimbursements. Staff is discussing with Health Services for Children with Special Needs (HSCSHN), the Medicaid MCO carve-out, the possibility of Medicaid reimbursements for oral health services at these schools.

Performance Measure 10: *The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.*

| Tracking Performance Measures<br>*[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]* | | | | | |
|---|---|---|---|---|---|
| **Annual Objective and** | | | | | |

| Performance Data | 2000 | 2001 | 2002 | 2003 | 2004 |
|---|---|---|---|---|---|
| Annual Performance Objective | 4.4 | 4 | 4 | 4 | 4 |
| Annual Indicator | 0 | 2.0 | 0.0 | 3.2 | 3.2 |
| Numerator | | 2 | 0 | 3 | |
| Denominator | | 97939 | 94092 | 93747 | |
| Is the Data Provisional or Final? | | | | Provisional | Provisional |
| | **2005** | **2006** | **2007** | **2008** | **2009** |
| Annual Performance Objective | 3 | 3 | 3 | 3 | 3 |

**Notes - 2002**

2001 is the most recent available data. There is a two year lag time for vital records information.

**Notes - 2003**

2002 is the most recent available data. Please note 2001 numerator has been changed from "3" to "2" based a recent report from SCHSA.

**Notes - 2004**

2003 is the most recent data

## a. Last Year's Accomplishments

The contract with a database developer to design a Web-based infant and child mortality review reporting system to support the infant and child fatality review functions, which was described in previous block grant reports, was fully operational. Administration staff continued to participate in the activities of the Child Fatality Review Committee. The committee's plans to implement a home visiting component, which consist of maternal in-home interviews and grief counseling and other services, got underway.

In January 2004, the Child Fatality Review Committee released a combined 2001 and 2002 Annual Report. For the 1st time since its establishment in 1992, the committee released the report at a joint meeting of the DC City Council human services committee and judiciary committee. During 2001-2002, 278 fatalities were reviewed. The extent to which the reviews covered all deaths that occurred in that time period was not disclosed. Ten of the deaths reviewed were due to automobile vehicle crashes, the major cause of unintentional injury deaths but a small number in comparison to the 68 homicides that came under the purview of the committee. There were no pedestrian deaths reviewed.

To help prevent injuries resulting from crashes, infant car seats were available to Medicaid beneficiaries free of charge and at reduced rental rates for others from the Department of Public Works and Project Safe Kids. HEALTHLINE staff provided this information in response to callers' requests. Healthy Start and Teen Mothers Take Charge clients are informed of the importance of using car seats and are told how to obtain them; in some instances a case manager or other staff person made the necessary arrangements for a client to obtain and install the car seat. Likewise, the CSHCN care coordinator arranged for car seats for those families with whom she came in contact through the infant screening and birth defects programs.

**Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet**

| Activities | Pyramid Level of Service | | | |
|---|---|---|---|---|
| | DHC | ES | PBS | IB |
| 1. Participate in and support Child Fatality Review Committee | | | | X |
| 2. Provide information on HEALTHLINE about free infant and child car seats | | | X | |
| 3. Healthy Start and Teen Mothers Take Charge case managers assist with obtaining car seats | | X | | |
| 4. CSHCN coordinator assists with obtaining car seats | | X | | |
| 5. | | | | |
| 6. | | | | |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

b. Current Activities

In FY 2005, the Administration continues to participate in all activities of the Child Fatality Review Committee, as well as to provide information on the availability of infant car seats through the HEALTHLINE, the hospital discharge planners, the Healthy Start and Teen Moms Take Charge care coordination, and follow-up to infant metabolic and hearing screening.

In May 2005, the infant mortality review process was expanded to include maternal interviews. The interviews provide additional information on the circumstances of the infant's demise and provide an opportunity to link the grieving mother to counseling and other resources. In FY 2005, plans are to interview 50-60% of mothers who lost an infant.

c. Plan for the Coming Year

The Administration will continue to incorporate information on the importance of the correct use of child and infant care seats and to supply information on how to obtain the seats into on-going care coordination and information dissemination activities.

Performance Measure 11: *Percentage of mothers who breastfeed their infants at hospital discharge.*

Tracking Performance Measures
*[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]*

| Annual Objective and Performance Data | 2000 | 2001 | 2002 | 2003 | 2004 |
|---|---|---|---|---|---|
| Annual Performance Objective | 46 | 55 | 57 | 58 | 60 |
| Annual Indicator | 38.0 | 46.0 | 51.0 | 65.5 | 65.5 |

| | | | | | |
|---|---|---|---|---|---|
| Numerator | 2913 | 3506 | 3822 | | |
| Denominator | 7666 | 7621 | 7494 | | |
| Is the Data Provisional or Final? | | | | Final | Provisional |
| | **2005** | **2006** | **2007** | **2008** | **2009** |
| Annual Performance Objective | 67 | 67 | 67 | 68 | 68 |

**Notes - 2002**

The most recent birth file data is for calendar year 2001.

**Notes - 2003**

Source: 2003 National Immunization Survey, CDC/DHHS
CI +-5.5

**Notes - 2004**

Provisional based on 2003 data

## a. Last Year's Accomplishments

The 4 contractors for Teen Mothers Take Charge were encouraged to have staff trained to support clients' breastfeeding. Healthy Start case management staff continued to counsel clients on the benefits of breastfeeding and to refer clients to WIC for services. Teen Mothers Take Charge contractors had active referral arrangements with WIC. Healthy Start case managers and Teen Mothers Take Charge contractors were informed of the resources for clients available at the Howard University Hospital Breastfeeding Drop-in Clinic, which was staffed by lactation consultants and was open 2 days weekly.

The Administration staff formed a breastfeeding task force in April 2004 to coordinate with citywide and national efforts around breastfeeding, such as the WIC agency's Loving Support initiative. Other efforts were organized under the auspices of the African American Breastfeeding Alliance and the Howard University Hospital BLESS initiative, funded in part by WIC and the US DHHS Office of Women's Health.

Several Administration staff attended a citywide conference Recapturing the Breastfeeding Tradition: The State of Breastfeeding in the African-American Community sponsored by Howard University September 26-27, 2003. BLESS and the African American Breast Feeding Alliance presented a workshop at the annual maternal and child health coordinating conference February 2004.

In December 2003 Administration staff began to work with BLESS to engage prospective fathers and fathers in support of breastfeeding. Healthy Start male outreach workers began to incorporate support for breastfeeding into their work with fathers by screening a video that shows African American men discussing their concerns about breastfeeding.

3 Administration HEALTHLINE staff, including the multilingual outreach worker to the Asian/Pacific Islander community, were trained and certified as WIC breastfeeding peer counselors in February 2004 in anticipation of providing telephone counseling via the HEALTHLINE.

**Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet**

| | |
|---|---|
| | **Pyramid Level of** |

| Activities | Service | | | |
|---|---|---|---|---|
| | DHC | ES | PBS | IB |
| 1. Healthy Start case management- information and counseling | | X | | |
| 2. Teen Mothers Take Charge- information and training of contractor | | X | | |
| 3. Provide print materials on lactation at hospital discharge | | | X | |
| 4. Educate fathers about breastfeeding. | | X | | |
| 5. | | | | |
| 6. | | | | |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

b. Current Activities

The Healthy Start case managers continue to provide individual counseling and education to their pregnant clients about the benefits of breastfeeding and encourage them to enroll in WIC services. Throughout the year, several group education sessions on breastfeeding for staff, clients and community members were held.

The one remaining Teen Mothers Take Charge contractor continues to make referrals to WIC services.

Although the Administration continues to be a member of the citywide Breastfeeding Task Force, plans reported in last year's application to coordinate several Administration-wide efforts to promote breastfeeding were put on hold. The centralization of the DOH telephone information and referral services in October 2005, described in the overview of the state section of this application, reduced the number of calls received by Administration staff, making it no longer practical to initiate proactive breastfeeding education with callers.

c. Plan for the Coming Year

In FY 2006, individualized counseling and education on breastfeeding will continue to be incorporated into Healthy Start and Teen Mothers Take Charge care coordination services. Healthy Start male outreach workers will continue to engage males in discussions of breastfeeding issues. Referrals will be made to WIC and to the Howard University Hospital Breastfeeding Drop-in Center.

One result of the DOH realignment described in the overview of the state section of this application is the incorporation of WIC and other nutritional services into the Nutrition and Physical Fitness Bureau. Administration management will explore opportunities for improved promotion of breastfeeding across DOH programs.

Performance Measure 12: *Percentage of newborns who have been screened for hearing before hospital discharge.*

Tracking Performance Measures
*[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]*

| Annual Objective and | 2000 | 2001 | 2002 | 2003 | 2004 |
|---|---|---|---|---|---|

| Performance Data | | | | | |
|---|---|---|---|---|---|
| Annual Performance Objective | 20 | 23 | 25 | 50 | 60 |
| Annual Indicator | 93 | 100.0 | 100.0 | 98.0 | 97.3 |
| Numerator | | 15763 | 14578 | 14477 | 14430 |
| Denominator | | 15763 | 14578 | 14777 | 14830 |
| Is the Data Provisional or Final? | | | | Final | Provisional |
| | **2005** | **2006** | **2007** | **2008** | **2009** |
| Annual Performance Objective | 100 | 100 | 100 | 100 | 100 |

**Notes - 2003**

Approximately 300 births may not have been screened at GSE hospital. Currently, staff is linking hearing screening data to the 2003 birth file to ascertain how many infant were actually missed.

**Notes - 2004**

Final data for 2004 has not all come in. Data will be updated after the block grant review.

## a. Last Year's Accomplishments

In March 2004, there were 4 tertiary care facilities in the District with comprehensive pediatric diagnostic auditory brainstem response (ABR) capabilities--Georgetown, Howard University Hospital, Children's National Medical Center and Hospital for Sick Children. The MCHB grant-supported staff continued to provide technical assistance on screening, including staff training and training in the use of the Web-based surveillance system to birthing hospitals. The surveillance and reporting were operational as intended in 5 of the 7 birthing hospitals, although data from 1 of the 5 had to be entered manually by Administration staff rather than by the hospital audiologist via the Web-based system.

One hospital, Greater Southeast Community Hospital, withdrew its participation from hearing screening, and referred newborns to Children's National Medical Center for screening. Because the patients were primarily Medicaid managed care recipients, the DC Hears director and the Medicaid managed care project officer were able to coordinate with the respective managed care organization to arrange initial hearing screening and any necessary follow up for the infants.

The extent to which the requirement for all birthing hospitals to have an audiologist to implement newborn screening had been incorporated into licensure and regulation of District hospitals was not determined.

Efforts to expand and coordinate existing diagnostic, treatment and early intervention services for infants and toddlers found to have hearing problems continued. The care coordinator also assisted with enrollment in the Early Intervention Program, arranged for cribs and car seats, and coordinated transportation to appointments. The project delivered continuing education seminars targeted to providers with Medicaid/SCHIP patient loads. A workshop was presented to the DC Chapter of the American Academy of Pediatrics March 2004.

The project director worked with the Alexander Graham Bell Association to stage training on

Learn to Talk Around the Clock, a new oral early intervention program designed to stimulate the language and listening development of infants and toddlers in their natural environments. 30 Early Intervention Program staff and contractors, speech language pathologists, educational audiologist and teachers completed the day long session.

**Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet**

| Activities | Pyramid Level of Service | | | |
|---|---|---|---|---|
| | DHC | ES | PBS | IB |
| 1. Provide loaner infant hearing aids | X | | | |
| 2. Support hospital screening and reporting, follow-up with positives to ensure early intervention | | | X | |
| 3. MIS integration across hospitals and with other screening databases | | | X | |
| 4. Educate/train providers and families | | | X | |
| 5. Provide equipment for hospitals | | | | X |
| 6. | | | | |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

b. Current Activities

Problems with hospital participation in screening, surveillance and reporting were resolved. All District hospitals with newborns are conducting universal screening.

The DC Hears Newborn Hearing Screening, Tracking and Intervention Advisory Board, meets annually and individual members are consulted as needed.

Staff continues to provide initial and booster training to child care center personnel to train them in the use of the ABR to screen young children.

Staff worked to stabilize and strengthen referral networks in the event of the Howard University audiology program's closure. The DC Public Schools established a community audiology center, which provides testing and hearing aids for persons up to age 22 and is a useful gap filling resource for clients until Medicaid enrollment can be completed. Equipment which was purchased for Howard University with newborn screening grant monies is being transferred to the DC Public Schools, which has agreed to become the newborn screening program community site for referral and follow-up services.

Arrangements were made for the Alexander Graham Bell Association to provide staff to established a special class for 8-12 children with impaired hearing in a DC public school. The school system subsequently agreed to institutionalize the class.

A new infant hearing screening grant was awarded by the MCHB. The grant includes monies to purchase loaner hearing aids, new testing equipment and provider education.
Equipment provided for the community site and hospitals will be upgraded. Because the grant provides for audiologist contractual services, the Administration may not need to fill the position of staff audiologist (the position was vacated in February 2005). A coordinator completed training in the use of ABR and is continuing to train child care facility staffs.

### c. Plan for the Coming Year

Staff will continue to support the hospital based newborn hearing screening program.

The new infant hearing screening grant will be implemented. Child care facilities will continue to receive training

## Performance Measure 13: *Percent of children without health insurance.*

Tracking Performance Measures
*[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]*

| Annual Objective and Performance Data | 2000 | 2001 | 2002 | 2003 | 2004 |
|---|---|---|---|---|---|
| Annual Performance Objective | 11 | 9 | 8 | 7 | 6 |
| Annual Indicator | 16 | 14 | 12 | 9 | 10 |
| Numerator | | | | | |
| Denominator | | | | | |
| Is the Data Provisional or Final? | | | | Final | Final |
| | **2005** | **2006** | **2007** | **2008** | **2009** |
| Annual Performance Objective | 6 | 6 | 6 | 6 | 6 |

**Notes - 2002**

2002 number is based on an estimate from the year before.

**Notes - 2003**

Source: The Henry J. Kaiser Family Foundation State Health Facts Online website www.statehealthfacts.org.

**Notes - 2004**

Source: The Henry J. Kaiser Family Foundation State Health Facts Online website www.statehealthfacts.org.

Distribution of Children 18 and Under by Insurance Status, state data 2002-2003, U.S. 2003

### a. Last Year's Accomplishments

Dissemination of information about eligibility for DC Healthy Families continued via the HEALTHLINE, DC Healthy Start and Teen Moms Take Charge. 13.6% of the 21,768 HEALTHLINE calls during FY 2004 were referred to DC Healthy Families, the Medicaid-SCHIP program.

**Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet**

| Activities | Pyramid Level of Service |
|---|---|

| | DHC | ES | PBS | IB |
|---|---|---|---|---|
| 1. HEALTHLINE provides callers with information on eligibility for and enrolling in Medicaid-SCHIP | | | X | |
| 2. Healthy Start-case managers assist clients with obtaining and retaining Medicaid and other insurance | | X | | |
| 3. Teen Mothers Take Charge- case managers assist clients with obtaining and retaining Medicaid and other insurance | | X | | |
| 4. | | | | |
| 5. | | | | |
| 6. | | | | |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

b. Current Activities

During FY 2005, the DOH central information telephone number, Healthy Start and Teen Mothers Take Charge activities to inform families about the availability and use of publicly supported health insurance are continuing.

c. Plan for the Coming Year

The Administration will participate in District-wide efforts to inform families of the availability of public insurance programs. The Administration will disseminate information about Medicaid-SCHIP and the Alliance at conferences, health fairs and through Healthy Start and the telephone information and referral service. Assisting women with public insurance enrollment and use will continue to ba an important part of care coordination services provided to Healthy Start and Teen Mothers Take Charge clients.

Performance Measure 14: *Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.*

Tracking Performance Measures
*[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]*

| Annual Objective and Performance Data | 2000 | 2001 | 2002 | 2003 | 2004 |
|---|---|---|---|---|---|
| Annual Performance Objective | 91 | 92 | 94 | 94 | 95 |
| Annual Indicator | 87.2 | 87.2 | 84.1 | 72.6 | 72.6 |
| Numerator | | | 71660 | 65357 | 65357 |
| Denominator | | | 85160 | 89993 | 89993 |
| Is the Data Provisional or Final? | | | | Final | Provisional |

| | 2005 | 2006 | 2007 | 2008 | 2009 |
|---|---|---|---|---|---|
| Annual Performance Objective | 96 | 96 | 96 | 96 | 96 |

**Notes - 2002**

Denominator for 2002 was taken from Form 416 - Total number of individuals eligible for EPSDT. The percentage estimate was based on the percentage used for this measure in previous years.

## a. Last Year's Accomplishments

The 4 Teen Mothers Take Charge contractors provided care coordination to teen mothers, including assisting with enrollment in Medicaid and obtaining recommended health services for themselves and their children for up to 4 years. The CSHCN grant-supported projects described in this application also contributed to the numbers of children who received Medicaid services. These services included newborn metabolic and hearing screening, school-based health services at Woodson, Sharpe and Mamie D. Lee schools, and birth defects surveillance. Deployment of staff for immunization clinics, the newborn discharge planning, and vision and hearing screening at selected sites may also have contributed to the utilization of Medicaid services to the extent that referrals presented for and received services from their Medicaid provider.

Healthy Start case managers followed clients for 2 years after birth and nurses encouraged and supported families in seeing that infants receive EPSDT and other services, thereby possibly increasing Medicaid utilization. HEALTHLINE information and referrals contributed to the receipt of needed Medicaid services as well.

**Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet**

| Activities | Pyramid Level of Service | | | |
|---|---|---|---|---|
| | DHC | ES | PBS | IB |
| 1. Healthy Start case management developmental screening and follow-up until infant reaches age 2 with referrals and follow through | | X | | |
| 2. Teen Mothers Take Charge- case managers assist with accessing health services and screening | | X | | |
| 3. Newborn metabolic and hearing screening follow-up referrals | | | X | |
| 4. Hearing screening follow-up referrals and early intervention | | X | | |
| 5. HEALTHLINE information dissemination and referrals | | X | | |
| 6. | | | | |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

## b. Current Activities

Staff is continuing the efforts described above to encourage and support clients and other recipients to utilize Medicaid services. During the period June -- August 2004, the Medicaid agency and the Maternal and Family Health Administration signed Memoranda of Understanding with each of the 4 managed care contractors, delineating areas of coordination of care for persons who are clients of both the Administration and the respective managed care organization. The agreement was formulated in broad terms, stating that each party will appoint

a liaison to work out specific protocols. Beginning in January 2005, the respective parties have been holding monthly information-sharing meetings.

An increased number of students at 2 public schools dedicated to children with special health care needs are receiving oral health services. (See NP# 9.) These are children who would not otherwise receive the services, or would have been delayed in receiving them. Arrangements are being put in place to receive Medicaid reimbursement for the services. Insofar as the District does not have a sufficient supply of dentists who accept Medicaid patients, this is potentially a significant expansion of services.

See also SP#3.

### c. Plan for the Coming Year

The Administration will continue to provide information to the MCH population on the importance of and availability of preventative services. Various grant-supported services will contribute to utilization of Medicaid services--HEALTHLINE, newborn screening, sickle cell services, Teen Mothers Take Charge and Healthy Start.

Staff will continue to pursue opportunities resulting from the MOUs with the Medicaid agency and the MCO contractors to integrate services, establish standards of care and improve outreach to clients. Monthly meetings of these parties will continue.

## Performance Measure 15: *The percent of very low birth weight infants among all live births.*

Tracking Performance Measures
*[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]*

| Annual Objective and Performance Data | 2000 | 2001 | 2002 | 2003 | 2004 |
|---|---|---|---|---|---|
| Annual Performance Objective | 3.1 | 3 | 2.9 | 2.9 | 2.8 |
| Annual Indicator | 2.7 | 2.7 | 2.7 | 2.3 | 2.3 |
| Numerator | 209 | 209 | 205 | 173 | |
| Denominator | 7666 | 7621 | 7490 | 7614 | |
| Is the Data Provisional or Final? | | | | Final | Provisional |
| | **2005** | **2006** | **2007** | **2008** | **2009** |
| Annual Performance Objective | 2 | 2 | 2 | 2 | 2 |

**Notes - 2002**

2001 is the most recent available data on District resident births. Vital records files have a two year lag time.

**Notes - 2003**

In 2003 there were 7,616 births. The denominator does not include 2 records missing

birthweight information.

**Notes - 2004**

2003 is the most recent data available.

## a. Last Year's Accomplishments

Case management and other services to pregnant women provided through the 2 federally funded Healthy Start projects and the Title V funded Teen Mothers Take Charge continued as described in previous years and in other sections of this application. The HEALTHLINE coordinated transportation services and conducted home visits to high-risk pregnant women in non-Healthy Start target areas, Wards 1 through 4. Transportation resources consisted of 3 drivers and 4 vans. Transportation via the HEALTHLINE continued to be provided to Medicaid beneficiaries only in special situations; Medicaid MCOs were responsible for transporting their clients. Transportation was provided to Healthy Start clients to participate in health education group sessions.

The MOU established in 2003 with the Addiction Prevention and Recovery Administration (APRA) continued to focus on the early identification of pregnant substance abusers at APRA's Women's Services Clinic. The scope of the MOU includes coordination of Healthy Start case management services with substance abuse treatment. As a result, a new position, Women's Services Liaison was established to assist with the coordination of services for women identified as pregnant.

Also see description of HIV/AIDS coordination activities in the state overview section of this application.

**Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet**

| Activities | Pyramid Level of Service | | | |
|---|---|---|---|---|
| | DHC | ES | PBS | IB |
| 1. Healthy Start outreach to identify pregnant women | | | X | |
| 2. Healthy Start case management to support entry into and retention in prenatal care | | X | | |
| 3. Teen Mothers Take Charge - case management assistance with prenatal care | | X | | |
| 4. | | | | |
| 5. | | | | |
| 6. | | | | |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

## b. Current Activities

In 2005, the Administration is continuing to offer transportation. Case management is still being offered to high-risk pregnant women through the Healthy Start and Teen Mothers Take Charge programs. Arrangements are made for home visits to high-risk pregnant women in non-Healthy Start target wards as necessary with subsequent referrals to other case management providers. Efforts to coordinate services for substance abuse clients are continuing as well.

c. Plan for the Coming Year

The Administration's 2 Healthy Start Project were refunded for the period June 2005 - May 2009. Efforts will refocus efforts on case finding and care coordination on "higher high risk" women who have multiple risk factors that may lead to poor perinatal outcomes.

The Prenatal Periods of Risk (PPOR) model to analyze infant mortality, first introduced in 2003 has helped the Administration to identify risks factors that are the greatest contributors to infant mortality. PPOR activity will be expanded and will continue to serve as a guide for Administration's efforts to further reduce infant mortality.

Performance Measure 16: *The rate (per 100,000) of suicide deaths among youths aged 15 through 19.*

Tracking Performance Measures
*[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]*

| Annual Objective and Performance Data | 2000 | 2001 | 2002 | 2003 | 2004 |
|---|---|---|---|---|---|
| Annual Performance Objective | 14 | 10 | 10 | 8 | 7 |
| Annual Indicator | 0 | 5.3 | 3.7 | 15.4 | 15.4 |
| Numerator | | 2 | 1 | 4 | |
| Denominator | | 37867 | 26668 | 25929 | |
| Is the Data Provisional or Final? | | | | Provisional | Provisional |
| | **2005** | **2006** | **2007** | **2008** | **2009** |
| Annual Performance Objective | 6 | 6 | 5 | 5 | 5 |

**Notes - 2002**

2001 is the most recent data for the District. There is a two year lag time for vital records files.

Please note population estimate has been updated. Population estimates taken from Table 2:Annual Estimates of the Population by Sex and Age for the District of cOlumbia April1, 2000 to July 1, 2004 (SC-EST2004-02-11) Source: Population Division US Census Bureau

**Notes - 2003**

2002 is the most recent available data. Please note 2001 numerator has been changed from "1" to "2" based on report from SCHSA.

Population estimates taken from Table 2:Annual Estimates of the Population by Sex and Age for the District of Columbia April1, 2000 to July 1, 2004 (SC-EST2004-02-11) Source: Population Division US Census Bureau.

Numerator based on ICD10 codes X60-X84 "intentional self harm"

**Notes - 2004**

2003 is the most recent year of data available.

## a. Last Year's Accomplishments

Although suicides are relatively rare in the District, homicide rates are high. Under the auspices of the HHS grant funded project--Youth Violence Prevention Architects Initiative--3 citywide youth summits at which experienced youth facilitators worked with youth age 11 to 20 to discuss issues related to violence and injury prevention were convened in January, April and May 2004. Partners included the Department of Health Bureau of Injury Prevention and Violence. 64 youth and 25 adults attended the first summit. The youth were recruited by a variety of organizations including DC Public Schools, faith based groups, the juvenile justice system and community based youth-serving organization. The May event resulted in recommendations presented to the mayor in person.

The Administration initiated outreach efforts at Ballou Senior High School to assist in developing intervention strategies to reduce youth violence overall as well as expand and enhance health-related services for adolescents. 3 meetings were held between October 2003 and February 2004 that involved school administrators along with representatives from community-based organizations such as Cease Fire Don't Smoke the Brothers, Casa Stride, East of the River Clergy, Police, Community Partnership, and Slam Your Stress. DC Department of Mental Health was also a contributor to this effort. In March of 2004 administrators from Ballou Senior High completed a Department of Mental Health needs assessment detailing current on-site programs and affiliations, current capacity to increase services, and apparent gaps in services. Intervention efforts concluded shortly thereafter due to changes in leadership at Ballou.

The Administration was one of the co-sponsors of a conference titled "Practical Approaches to Dealing with the Effects of Violence and Trauma on Children" which targeted providers of youth services. Both the public health perspective and the youth development perspective to violence were presented. The event sought to better equip service delivery personnel in research-based yet practical approaches to managing and serving children who have been adversely affected by violence. The conference was successfully executed in November 2004 and hosted approximately 100 attendees.

In 2004, staff of the male outreach component of the Healthy Start Project formed a support group for male students at Woodson Senior High school was initiated in response to concerns about increasing violent behavior.

In June 2004, MFHA applied to the CDC to receive a 2-year planning grant designed to foster statewide capacity and leadership in preventing the perpetration of violence toward and among children and adolescents so as to raise it as a public health priority. The application was accepted but not funded.

**Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet**

| Activities | Pyramid Level of Service | | | |
|---|---|---|---|---|
| | DHC | ES | PBS | IB |
| 1. Participate in and support Child Fatality Reviw | | | | X |
| 2. Implement violence prevention planning recommendations to extent possible | | | | X |
| 3. | | | | |
| 4. | | | | |
| 5. | | | | |

| | | | | |
|---|---|---|---|---|
| 6. | | | | |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

b. Current Activities

The Administration collaborated with several community organizations in planning a town hall meeting on Ending Youth Violence, which took place at Lincoln Theatre in November 2004. Dr. Debra Prothrow-Stith, one of the nation's leading authorities on youth violence prevention, delivered the keynote, and further agreed to assist the Administration in long range development of its youth violence prevention initiatives.

Friendship Edison Schools' Center for Student Support Services is charged with providing behavioral health services to students currently enrolled at the site. In light of recent concerns at the school, the Injury Prevention Coalition of Children's National Medical Center and the Administration sponsored "student rap sessions" for the entire 6th grade class as part of their social skills curriculum. Currently, the Administration and Children's National Medical Center are preparing to conduct small focus groups with the 6th grade population to further assess the nature of their concerns and the actual needs of the population. Sessions, slated to begin in September 2005, are likely to focus on conflict management and resolution, effective communication, and positive decision-making.

Insofar as the violence prevention initiatives are not funded, significant time is being devoted to further fostering collaborative relationships with government and community partners in an effort to assist organizations and agencies who focus their efforts on reducing the incidence of violence among adolescents in the District.

c. Plan for the Coming Year

The Administration will participate in the city-wide coalition for youth violence prevention, a high profile group that consists of government, community and faith-based organizations. The Administration's role will be, in part, to brief city officials on effective public health and youth development approaches to violence prevention. Staff will seek funding opportunities to operationalize the recommendations from the youth summit described above.

The proposed realignment of the DOH includes the transfer of a violence prevention program (primarily focusing on sexual assault) to the Administration, increasing the opportunities for a more integrated violence prevention intervention strategy. Staff will be assisted to exploit opportunities to coordinate and integrate violence prevention programs.

Within resource constraints, staff will continue to work with, support, and build the skills of youth services organizations.

Staff will continue to support the activities of the Child Fatality Review Committee.

Performance Measure 17: *Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.*

| Tracking Performance Measures<br>*[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]* | | | | | |
|---|---|---|---|---|---|
| | | | | | |

| Annual Objective and Performance Data | 2000 | 2001 | 2002 | 2003 | 2004 |
|---|---|---|---|---|---|
| Annual Performance Objective | 74 | 75 | 76 | 78 | 79 |
| Annual Indicator | 71.6 | 78.0 | 71.2 | 79.2 | 79 |
| Numerator | 149 | 163 | 146 | 137 | |
| Denominator | 208 | 209 | 205 | 173 | |
| Is the Data Provisional or Final? | | | | Final | Provisional |
| | **2005** | **2006** | **2007** | **2008** | **2009** |
| Annual Performance Objective | 80 | 80 | 80 | 80 | 80 |

**Notes - 2002**

2001 is the most recentl available birth data. The lag time for Vital records files is two years.

**Notes - 2003**

Numerator includes births from Howard University Hospital, Washington Hospital Center, George Washington University Hospital, Georgetown University Hospital and 22 resident births occuring out of the District.

**Notes - 2004**

2003 is the most recent available year for data.

## a. Last Year's Accomplishments

The Child Fatality Review Committee combined annual reports for 2001 - 2002, released in January 2004, listed as 1 of its top 10 recommendations, the evaluation of the availability of tertiary care for high-risk mothers and infants, including at a minimum, barriers such as the impact of lack of insurance, bed availability, staffing patterns and MCO/HMO restrictions. To date, no steps have been reported toward the recommendation. Healthy Start management continued to work with March of Dimes (MoD) representatives to present (PPOR) to stakeholders, including the Healthy Start consortium. Administration management decided to take initial steps to form a DC perinatal association. Contacts were made with the National Perinatal Association, and the president participated in presentations to stakeholders. Potential founding members were recruited and an invitational meeting took place on July 28, 2004. In May 2004 staff examined the out-of-state vlbw deliveries; as a result of this analysis, it was found that 40 vlbw babies were delivered at level III hospitals in the Maryland and Virginia suburbs. This increased the proportion of 2001 vlbw deliveries at level III facilities from 59 to 78%. In the months that followed staff reexamined 1999 and 2000 births. It was determined that corrections in tracking data (Form 11) were warranted.Through Healthy Start, the Administration began work with the March of Dimes to implement the Perinatal Periods of Risk (PPOR) model. A preliminary analysis of perinatal data was compiled and presented to several stakeholder groups. The maternal and child health officer worked with sister agencies involved with the development of a state health system plan in an attempt to obtain data on emergency transport services of high risk pregnant women, as well as emergency medical services protocols regarding pregnant clients.

**Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet**

| Activities | Pyramid Level of Service | | | |
|---|---|---|---|---|
| | DHC | ES | PBS | IB |
| 1. Healthy Start to begin PPOR data compilation and obtain EMS transport data | | | | X |
| 2. Participate in DOH health systems planning | | | | X |
| 3. Form DC perinatal association | | | | X |
| 4. | | | | |
| 5. | | | | |
| 6. | | | | |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

## b. Current Activities

The process of analyzing data collection of the birth records files, to determine the extent to which births in hospitals outside the District are affecting this performance measure, continues. Information is included in presentations to the emerging perinatal association.

While the District has had an IMR process in place for several years, unlike many other states and cities, we had a one tier process that involved only the clinical record review. During the period of 2001 -- 2004, The Administration was a member of the City-Match Action Learning Lab on Perinatal Periods of Risk. Perinatal Periods of Risk (PPOR) is based on the World Health Organization's model for analyzing infant mortality. The model was used to identify the risk periods for women in the District of Columbia, using infant mortality data for 2000-2002. In the fall of 2004, Healthy Start organized and launched the 2nd tier to the IMR process--Community Action Teams (CAT). The CAT membership consists of representatives from community-based organizations and agencies, such as the Family Strengthening collaboratives, Metropolitan Washington March of Dimes, Healthy Babies, the Medicaid MCOs, and will be responsible for the implementation of IMR recommendations at the community-level. Orientation for CAT members was held January 2005 and included an overview of IMR process and participation in at least one IMR meeting, IM data for the District of Columbia, role of CAT, and community action plans. The CAT meets quarterly, during which it reviews IMR recommendations and develops a consensus on community action plan. A formal evaluation of PPOR and the CAT is planned during the next project period. As of June 2005, 9 individuals have participated in 2 CAT meetings, with a 3rd meeting scheduled for the September 2005. The team is working on the identification of community bereavement services and support materials. This information will be used to inform and educate health professionals, clergy, and funeral directors. The DOH will disseminate the information.

## c. Plan for the Coming Year

The use of the PPOR model will continue and the Administration will increase its efforts and allocate available resources as needed to implement appropriate intervention strategies. Staff will collaborate more closely with Medical Assistance Administration to determine the percentage of high-risk pregnant women who are delivering at Level II and III facilities. In addition, the Administration will renew its efforts to facilitate the establishment of a prenatal association for the District.

Performance Measure 18: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.*

| Tracking Performance Measures *[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]* | | | | | |
|---|---|---|---|---|---|
| **Annual Objective and Performance Data** | **2000** | **2001** | **2002** | **2003** | **2004** |
| Annual Performance Objective | 77.9 | 81.1 | 84.4 | 87.9 | 91.5 |
| Annual Indicator | 74.0 | 74.4 | 75.5 | 75.3 | 75 |
| Numerator | 4706 | 4859 | 4885 | 5206 | |
| Denominator | 6356 | 6529 | 6469 | 6918 | |
| Is the Data Provisional or Final? | | | | Final | Provisional |
| | **2005** | **2006** | **2007** | **2008** | **2009** |
| Annual Performance Objective | 75 | 75 | 78 | 78 | 80 |

**Notes - 2002**

2001 is the most recent data available. There is a two year lag time for vital records data. The denominator for 2001 excludes 1092 births with unknown/missing entry into prenatal care information.

**Notes - 2003**

There were 7,616 births in 2003. The Denominator does not include 698 missing entry into prenatal care data.

**Notes - 2004**

2003 is the most recent data available.

a. Last Year's Accomplishments

See SP#1

**Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet**

| Activities | Pyramid Level of Service | | | |
|---|---|---|---|---|
| | **DHC** | **ES** | **PBS** | **IB** |
| 1. Healthy Start- identification of women early in pregnancy for risk assessment and enrollment in case management | | **X** | | |
| 2. HEALTHLINE callers receive information about benefits of early and consistent prenatal care | | | **X** | |
| 3. Teen Mothers Take Charge case management | | **X** | | |
| 4. | | | | |
| 5. | | | | |
| 6. | | | | |
| | | | | |

| | | | | |
|---|---|---|---|---|
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

b. Current Activities

Activities described under SP#1 are continuing throughout the current period.

c. Plan for the Coming Year

Healthy Start outreach staff will continue community activities to encourage early and sustained prenatal care, including working with males to support their roles as fathers and partners. Also see SP#1. HEALTHLINE will continue to disseminate information on the importance of and where to obtain prenatal care.

The Healthy Start project is in the process of procuring a new "state-of-the-art" mobile unit. The mobile unit will be re-deployed in neighborhoods with high prevalence rates for adverse perinatal outcomes. Services will include pregnancy testing, assessment, screening and referral. The mobile unit will be staffed by a family nurse practitioner that will be able to provide the equivalent of the first prenatal visit to women who test positive and who have not yet seen a provider.

The Medicaid MCOs have identified difficulties in identifying pregnant members. The Administration will pursue the opportunity for collaboration between Healthy Start and the MCOs for early identification of their members through the use of the mobile unit.

## D. STATE PERFORMANCE MEASURES

State Performance Measure 1: *Percent of live births to women who receive adequate prenatal care (Kotlechuck)*

Tracking Performance Measures
*[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]*

| Annual Objective and Performance Data | 2000 | 2001 | 2002 | 2003 | 2004 |
|---|---|---|---|---|---|
| Annual Performance Objective | 62. | 63.4 | 64.9 | 66.4 | 67.9 |
| Annual Indicator | 60.2 | 64.9 | 60.2 | 59.2 | 59.2 |
| Numerator | 3727 | 4235 | 3794 | 3946 | |
| Denominator | 6189 | 6529 | 6306 | 6664 | |
| Is the Data Provisional or Final? | | | | Final | Provisional |
| | **2005** | **2006** | **2007** | **2008** | **2009** |
| Annual Performance Objective | 69.5 | 70 | 70.5 | 70.5 | 70.5 |

**Notes - 2002**

2001 data does not include 1092 births which had missing data. 2001 is the most recent available vital records data for the Dsitrict of Columbia. There is a two year lag time for vital records data.

**Notes - 2003**

2003 is the most recent year of data available. Denominator does not include 952 records with missing information.

**Notes - 2004**

2003 is the most recent year of data available.

## a. Last Year's Accomplishments

Planning and assessment efforts based on this measure, as well as a number of other national and state measures, were hampered by the quality of vital records data. From CY 1997 to 2003, the rate of missing data on this measure has ranged from 16 to 21%. Whether the missing cases are included in the denominator has a considerable effect on the rate of adequacy of care. While arguments can be made for either approach, the denominator reported on Form 11 excludes missing data. Although the proportion of missing data has decreased in the past 2 years, no comprehensive analysis of the distribution of missing data has been reported.

The Administration and the State Center for Health Statistics Administration negotiated an MOU, delineating responsibilities for acquiring and sharing data, and outlining the rights and responsibilities for linkage and integration of the data systems described throughout this application. The Administration provided funds for data acquisition. Birth records constitute the base for most of these systems. The MOU was signed August 2003.

The 2 federally funded Healthy Start projects operated by the Administration focused on locating low income, African American pregnant women in underserved areas of Ward 5, 6, 7 and 8, and provided nurse case management and home visits to ensure that they received necessary and sustained prenatal care. A cadre of indigenous outreach technicians was responsible for case finding. In FY 2003 Healthy Start added depression screening and referrals to mental health services with the expectation that recognition of and treatment for depression may contribute to better compliance with prenatal care. 511 women received an initial screen in FY 2004.

3 Teen Mothers Take Charge (see SP #7) contractors continued to provide care coordination, education and enrichment services to pregnant and parenting teens. Although the overall budget was reduced 20%, a 4th contract was awarded (MELD/Even Start). Approximately 50% of the teens enrolled prior to the birth of the infant. Enrollment in and adherence to prenatal care was a component of the care coordination services offers by the contractors.

Door-to-door transportation was provided to prenatal care for women not eligible for Medicaid transport. 232 trips were provided in FY 2004.

**Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet**

| Activities | Pyramid Level of Service | | | |
|---|---|---|---|---|
| | DHC | ES | PBS | IB |
| 1. Healthy Start case management, outreach and health education | X | X | | |
| 2. Teen Mothers Take Charge care coordination | | X | | |
| 3. HEALTHLINE information dissemination | | X | | |
| | | | | |

| | | | | |
|---|---|---|---|---|
| 4. Coordination of outreach and case finding with Medicaid MCOs | | | | X |
| 5. | | | | |
| 6. | | | | |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

b. Current Activities

In addition to the continuation of Healthy Start strategies, the Administration is continuing the strategies used in previous years to support early and continuous prenatal care: door to door transportation to prenatal care for uninsured clients, home visiting and client outreach to high risk cases identified through the HEALTHLINE, and information and referrals through the HEALTHLINE and health fairs.

The Teen Mothers Take Charge program was reduced from 4 contractors to1, due to lack of funds. 75 teens and their families are receiving services.

Healthy Start staff submitted successful applications for refunding the projects. Both projects were refunded at level funding through 2009.

c. Plan for the Coming Year

Teen Moms Take Charge and Healthy Start activities will continue through FY 2006. Among their other objectives, both programs include case finding to support pregnant women's entry into and adherence to prenatal care.

A new, 1-year grant from MCHB will allow for the extension of perinatal depression screening throughout the city.

Administration staff will continue to meet with Medicaid and MCO representatives around coordination of case finding and outreach, and other strategies to get pregnant women into and sustain them in prenatal care.

State Performance Measure 3: *Percent of Medicaid enrolles receiving EPSDT screening*

Tracking Performance Measures
*[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]*

| Annual Objective and Performance Data | 2000 | 2001 | 2002 | 2003 | 2004 |
|---|---|---|---|---|---|
| Annual Performance Objective | 60 | 65 | 70 | 75 | 80 |
| Annual Indicator | 69.8 | | 63.3 | 71.0 | 71.3 |
| Numerator | 35904 | | 35108 | 46382 | 49951 |
| | | | | | |

| | | | | | |
|---|---|---|---|---|---|
| Denominator | 51445 | | 55436 | 65357 | 70102 |
| Is the Data Provisional or Final? | | | | Final | Final |
| | **2005** | **2006** | **2007** | **2008** | **2009** |
| Annual Performance Objective | 75 | 75 | 78 | 78 | 80 |

**Notes - 2004**

Source: District of Columbia Form 416 FY04 Annual EPSDT Participation Report provided by the Medical Assistance Administration

## a. Last Year's Accomplishments

This measure is related to the priority to eliminate racial, ethnic, immigrant status and class disparities in birth outcomes and child health status and to NO# 1, 2, 4 and 6.

Since 1992 the participation ratio increased from 26% to 71.3% in 2004, but remains considerably short of the federal goal of 80%, which few states have achieved. 2004 saw an increase in the number of children due for 1 or more EPSDT screen (denominator).

The Healthy Start projects maintained clients in case management for 2 years after the birth of the baby. The 4 Teen Mothers Take Charge contractors extended their care coordination of clients up to 4 years after birth, although to a smaller number of clients due to budget reductions of 20%. Case managers tracked well-baby visits and worked with the mothers and their primary care providers to ensure that the appropriate immunizations, and health screens and follow-up were obtained for infants and toddlers. Healthy Start staff members were trained to administer the Denver Development screens so that developmental delays could be referred directly for diagnosis and follow-up.

The oral health services provided to children (see NP# 9) may have contributed to increased EPSDT participation as well.

The Administration has used Healthy Start funds to operate an adolescent wellness center at H.D. Woodson Senior High School for nearly 8 years. The center is open 5 days per week year round. Students can obtain EPSDT services such as physical exams and immunizations. In FY 2004 there were 1950 visits to the center. After an extended vacancy in the position of physician, Healthy Start contracted with Georgetown University Medical Center to provide an adolescent health physician(s) to staff the Woodson Senior High School Wellness Center 10 hours weekly beginning January 2004.

Also see activities described for NP # 7, 13 and 14, and SP#3.

**Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet**

| **Activities** | **Pyramid Level of Service** | | | |
|---|---|---|---|---|
| | **DHC** | **ES** | **PBS** | **IB** |
| 1. Healthy Start case management and infant developmental screening | **X** | **X** | | |
| 2. Teen Mothers Take Charge care coordination | | **X** | | |
| 3. HEALTHLINE information to callers | | **X** | | |
| 4. Support of lead screening program | | | | **X** |
| | | | | |

| | | | | |
|---|---|---|---|---|
| 5. MIS integration and linkage projects | | | | X |
| 6. Participation in Medicaid MCO meetings | | | | X |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

## b. Current Activities

See NP# 9 on Salazar.

In summer 2004, there was an amended court order for dental health services. The District was required to submit a corrective action plan to increase Medicaid reimbursement for dental services, provider fees and dentist participation, and to increase several measures of oral health services utilization, as referenced in Healthy People 2010 and Title V plans. According to state Medicaid agency (MAA) staff, and as recorded on the required 416, the low EPSDT participation among fee-for-service recipients is a major problem. This population of approximately 9000 includes about 5000 foster children, many of whom reside outside the District and/or in institutional settings. It is much more difficult to obtain reports on EPSDT services to these children. MAA has taken several steps to improve provision of oral health services to the Medicaid population--outreach efforts have increased, and the enrollment broker has established a dental health telephone line to assist clients with answers to questions about coverage and locating a dentist. In January 2006, a provider fee increase will take effect. A standard record form has been designed and will be pilot-tested this summer. Use of the standard record form will allow for information from well child visits (EPSDT) to be captured. The record will be linked to the immunization registry and the lead registry, both maintained by DOH, to establish a child health registry. The system is also designed to generate a uniform health record, which is required by the public schools, day care centers and other institutions providing services to children.

Activities described and referenced above are continuing. The Teen Mothers Take Charge project was reduced to 1 contractor serving 75 teens and their families. The Administration negotiated MOUs with each of the 4 Medicaid managed care contractors, and began monthly meetings in the spring of 2005. An on-going issue with the MCOs is EPSDT compliance.

## c. Plan for the Coming Year

In FY 2006, the Administration will continue the numerous efforts that may contribute to EPSDT utilization: The 2 Healthy Start projects have been refunded at level funding through 2009. Nurse case managers will continue to encourage clients to comply with well child visits. Teen Mothers Take Charge will continue with 1 contractor, providing services to 95 teens. The newborn initiative-hospital based discharge planning (see other activities) will continue. MIS integration and linkage with Medicaid claims will continue. The Medical Assistance Administration has entered into an agreement with Georgetown University Hospital to provide 4 hours in-service Web-based training to 20 targeted providers for CME credits on the Bright Futures curriculum to assist with EPSDT achievements goals. Other providers across the District will be able to log-in and receive this training during their downtime August 1 -- September 30, 2005.

Staff will continue to meet with Medicaid MCO representatives to coordinate outreach strategies for enhanced greater collaboration among the District's Title V and Title XIX agencies.

State Performance Measure 4: *Prevalence of lead levels > 10 ug/dL among chldren through age 6*

Tracking Performance Measures
*[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]*

| Annual Objective and Performance Data | 2000 | 2001 | 2002 | 2003 | 2004 |
|---|---|---|---|---|---|
| Annual Performance Objective | 3.3 | 2.9 | 2.7 | 2.4 | 2.2 |
| Annual Indicator | 6.8 | 9.9 | 5.8 | 1.8 | 1.3 |
| Numerator | 1488 | 2201 | 1322 | 400 | 329 |
| Denominator | 21860 | 22210 | 22820 | 22138 | 26311 |
| Is the Data Provisional or Final? | | | | Final | Final |
| | **2005** | **2006** | **2007** | **2008** | **2009** |
| Annual Performance Objective | 1.9 | 1.9 | 1.9 | 1.9 | 1.9 |

**Notes - 2002**

2002 data is for FY2001

**Notes - 2003**

FY03 data is the most recent information available. Data reported reflects number screened (denominator) through the Childhood Lead Poisoning, Screening, Education Program (CLPSEP) and results over 10 ug/dL (numerator). Program is unable to provide prevalence levels at this time. However, during FY04 CLPSEP purchased tracking software that will facilitate this in the future. MCH staff will work with the program to enusre that prevalence data is available for FY05.

**Notes - 2004**

FY04 data is the most recent information available. Data reported reflects number screened (denominator) through the Childhood Lead Poisoning, Screening, Education Program (CLPSEP) and results over 10 ug/dL (numerator). Program is unable to provide prevalence levels at this time. During FY04 CLPSEP purchased tracking software that will facilitate this in the future. Currently, MCH staff are working with the program to obtain prevalence data.

a. Last Year's Accomplishments

For several years, Title V funds have been applied to the Comprehensive Lead Poisoning Prevention Program (CLPPP) to supplement CDC and HUD funding. Mutual responsibilities were delineated in an interagency memorandum of understanding between the Administration and the CLPPP, which is located in the DOH Environmental Health Administration, signed in July 2002 to be renewed annually; however, renewal did not occur in 2003.

CLPPP staff reported that 26,311 screening were conducted in FY 2004, compared to 22,138 in FY 2003, a number equivalent to about 50% of children under 6 years of age. However, the number of reported screens may include duplicates or retests. A population-based prevalence estimate has yet to be generated. During FY 2004 the program purchased tracking software that will facilitate this in the future. .In FY 2004, 1.3% of screenings were found to have lead levels exceeding 10 ug/dl (and .7% exceeded 15ug/dl). 23% of the screenings were conducted

by CLPPP staff. The CLPPP continued to provide medical case management for children with confirmed blood lead levels > 15ug/dl. Employees conducted home visits to 253 newly identified children to assure compliance with referrals. Staff also collected dust samples, arranged lead abatement, taught parents and caregivers about harm reduction, and performed in-home screening for resident children.

In January 2004, the public became aware that the results of the expanded water testing indicated that the majority of homes tested had water lead levels above EPA's action level of 15 parts per billion (ppb). A flurry of water testing in private homes, schools and child care centers ensured, often with inconsistent findings. The media attention and public outcry about water safety and release of information to the public brought increased attention to the more general problem of lead poisoning and elevated lead levels. An investigation by CDC was hampered by the lack of compliance with childhood lead screening requirements. There is no way to know whether a child has not been tested or whether the child was tested and tested negative. District law gives officials authority to take criminal or civil action against physicians and labs, but the law has not been enforced.

The director of the CLPPP released a prevalence level estimate in an interview with The Washington Post--3700/45549 = 8% , something that Administration representatives have been requesting for several years. And as a result of public concern, government officials approved expenditures to enhance reporting: The DOH contracted with Welligent Corporation to design, install and support a Web-based lead registry--Lead Tracks, which went live April 2004. It is expected that data from the registry can be easily linked with the Administration's UNITS and with the MAA's Medicaid information systems.

Also see NP#9 Salazar.

**Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet**

| Activities | Pyramid Level of Service | | | |
|---|---|---|---|---|
| | DHC | ES | PBS | IB |
| 1. Support DOH lead poisoning prevention and control program | | | X | |
| 2. Integrate CLPPP and Child Health Services Bureau | | | | X |
| 3. Inform Healthy Start and Teen Mothers Take Charge clients | | X | | |
| 4. MIS integration and linkage projects | | | | X |
| 5. Disseminate information to HEALTHLINE callers | | X | | |
| 6. | | | | |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

b. Current Activities

Although the cause of the elevated water lead levels continues to be studied, a change in the disinfection process from chlorine to chloramines that occurred in November 2000 and contributed to the deterioration of lead service pipes is now considered the likely primary cause. The advisory continues in effect.

As of February 2005, 3,290 screenings had been completed, 478 by CLPPP staff. Nearly 3% exceeded 10ug/dl. The CLPPP staff is continuing informational, educational and testing

activities, including follow up of children found to have elevated levels. The Administration continued to fund 14 FTEs in the CLPPP.

### c. Plan for the Coming Year

The Administration will continue to provide funds to support the operation of the CLPPP and participate in the activities described above. Efforts to link other data systems with the lead registry will continue. The CLPPP is being moved from the Environmental Health administration to the Maternal and Family Health Administration, where it will be located in the Child Health Services Bureau with CSHCN programs. Once this organizational change is accomplished, management will work with staff to determine if there are ways to integrate lead screening and prevention education activities with other Administration program.

A notice of award for a lead exposure prevention grant has been received for FY 2006. The purpose of the grant is to conduct assessments and remediation of leaded water pipes, followed by comprehensive risk assessments of children in homes with lead exposure.

The DOH will continue to work toward linking the lead registry with Medicaid EPSDT reporting and the Administration's data base. A centralized data warehouse strategy will be piloted.

## State Performance Measure 5: *Prevalence of tobacco use among pregnant women*

Tracking Performance Measures
*[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]*

| Annual Objective and Performance Data | 2000 | 2001 | 2002 | 2003 | 2004 |
|---|---|---|---|---|---|
| Annual Performance Objective | 3.1 | 3.1 | 2.7 | 2.3 | 1.9 |
| Annual Indicator | 2.6 | 3.7 | 3.9 | 3.7 | 3.7 |
| Numerator | 200 | 282 | 290 | 284 | |
| Denominator | 7663 | 7621 | 7494 | 7615 | |
| Is the Data Provisional or Final? | | | | Final | Provisional |
| | **2005** | **2006** | **2007** | **2008** | **2009** |
| Annual Performance Objective | 1.7 | 1.7 | 1.7 | 1.7 | 1.7 |

**Notes - 2002**

2001 is the most recent available data for the District. There is a two year lag time for vital records data.

**Notes - 2003**

In 2003 there were 7,616 live births. The denominator does not include 1 case with missing information.

**Notes - 2004**

2003 is the most recent available data.

## a. Last Year's Accomplishments

This measure may be related to the priorities: Increase the proportion of the population that is insured, and increase the comprehensiveness of the insurance to include primary preventative services and preconception health care and elimination of racial, ethnic, immigrant status and class disparities in birth outcomes and child health status. The measure is associated with NP# 15 and NO# 1-6.

Although the prevalence of tobacco use has decreased from nearly 7% in 1996 to 3.7% in 2003, the rate has been stable for the past 3 years. Tobacco use data collected for the birth certificate are considered to be highly variable by hospital and provider and may be grossly under reported.

According to a report released in November 2003 by Tobacco Free Kids http://tobaccofreekids.org/reports/settlements/2004/fullreport.pdf, the District ranked last among states on the extent to which it funded tobacco control and prevention efforts. The District has not allocated tobacco settlement monies to tobacco control and prevention. A cigarette tax increase took effect January 1, 2003, increasing the tax on cigarette, by 35 cents to $1 per pack. These revenues were not dedicated to tobacco control.

In fiscal year 2004, the District's Synar Amendment noncompliance rate of 41.9% exceeded the 20% target rate set by federal standards.

Although the final year of the American Legacy grant was FY 2003, $192,000 of carry over funds were used in FY 2004 for outreach and to finish some of the projects and activities initiated with the grant. The grant was directed toward preventing the onset of smoking by teens. The extent to which the community-based organizations that started programs as a result of Legacy funds have been able to continue with other funding has yet to be determined.

Healthy Start health educators offered smoking cessation at community sites and occasionally via home visits in the Wards of the city where smoking rates are highest. In FY 2004, a total of 768 smoking cessation sessions were held.

**Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet**

| Activities | Pyramid Level of Service | | | |
|---|---|---|---|---|
| | DHC | ES | PBS | IB |
| 1. Disseminate print materials at health fairs and other events | | X | | |
| 2. Teen Mothers Take Charge – information and counseling | | X | | |
| 3. Healthy Start – information and counseling | | X | | |
| 4. Healthy Start health education smoking cessation sessions | X | | | |
| 5. Coordinate with DOH tobacco control program quit line | | | | X |
| 6. | | | | |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

## b. Current Activities

The Healthy Start program continues to incorporate counseling about tobacco use into case management services, as does Teen Mothers Take Charge. Healthy Start health educators

offer smoking cessation sessions to clients and other community residents.

The DOH tobacco control program, which is located in another administration, convened a 2 day meeting (May 12 and June 1, 2005) with stakeholders to discuss the possibility of establishing a quit line in the District. DOH is awaiting notification of a pending grant award for July 1, 2005 through June 30, 2006 for continued development of a quit line. Currently DC Medicaid pays for Zyban and nicotine nasal spray. It was agreed that the quit line project should work with Medicaid, the Alliance, and the 4 Medicaid HMOs to expand and enhance coverage not only for counseling, only for pharmacotherapy services. Several of the Medicaid HMOs reportedly offer resources to which the quit line could refer callers. The quit line can encourage the HMOs to develop additional group counseling and support services for their members. Demand for these services may be increased if the quit line is established. DC Medicaid pays for tobacco use assessment and referral by physicians and is moving toward reimbursement of tobacco cessation services. Medicaid eventually could provide a funding stream for the quit line.

Smoke free workplace legislation to include restaurants and bars was introduced in the District and as a result the level of public debate about the effects of smoking and environmental exposure has increased.

### c. Plan for the Coming Year

Healthy Start staff and the Teen Mothers Take Charge contractor will continue to incorporate the dissemination of information and counseling about tobacco use into case management and health education efforts. Healthy Start health educators will continue to offer smoking cessations to pregnant and interconceptional clients.

Administration staff will attempt to contact and work with the DOH tobacco control program and to advocate for accessible and culturally acceptable quit line services for the MCH populations.

The Administration's Women's Health Initiative will offer training to staff, other DOH employees and community based providers in the delivery of a gender-based smoking cessation curriculum.

## State Performance Measure 7: *Proportion of unintended pregnancy*

Tracking Performance Measures
*[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]*

| Annual Objective and Performance Data | 2000 | 2001 | 2002 | 2003 | 2004 |
|---|---|---|---|---|---|
| Annual Performance Objective | 45 | 43 | 41 | 40 | 38 |
| Annual Indicator | 54.1 | 59 | 51 | 51 | 50 |
| Numerator | | | | | |
| Denominator | | | | | |
| Is the Data Provisional or Final? | | | | Final | Provisional |

| | 2005 | 2006 | 2007 | 2008 | 2009 |
|---|---|---|---|---|---|
| Annual Performance Objective | 37 | 37 | 37 | 36 | 36 |

**Notes - 2002**

Data are obtained from the DC Pregnancy Risk Assessment Monitoring System (PRAMS). The most recent information available is for calendar year 2001. There is a two year lag time between the closeout and cleanup of the file and when analysis is completed.

**Notes - 2003**

Data is based on results of PRAMS survey for 2003.

**Notes - 2004**

2003 is the most recent data available for PRAMS.

## a. Last Year's Accomplishments

This measures the priority: Reduce unintended pregnancies and teen births. Unintended pregnancies are correlated with late entry into prenatal care and inadequate care, and may have a direct relationship to NO# 1, 5 and 6. The most recent estimate of the prevalence of unintended pregnancies is 50%; it has changed very little since tracking was initiated.

4 Teen Mothers Take Charge community-based contractors provided care coordination and other services to 1st time pregnant and parenting teens to prevent repeat teen pregnancies. During this period, teens, their partners and other family members received a variety of supportive, mentoring and enrichment services intended to encourage them to continue their training and education and to avoid unplanned pregnancies. A grant funded abstinence education program worked with youth service providers to expose children to the "I'm Worth the Wait" curriculum. (See SP# 7.)

In conjunction with Healthy Start community outreach, condoms were distributed and birth control information made available at convenient neighborhood locations. Information and referrals for birth control services, and condoms were available curbside through the mobile unit until it was retired August 2003. The HIV/AIDS Administration also operated an extensive prevention education and condom distribution program.

Healthy Start staff attempted to maintain high-risk women in case management for 2 years after delivery to coordinate interconception health care, with an emphasis on family planning services.

Title V funds supported the PRAMS, administered by the Administration's data collection and analysis division, which collects data from a sample of women post delivery, providing data to track this measure over time.

See also NP# 9.

**Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet**

| Activities | Pyramid Level of Service | | | |
|---|---|---|---|---|
| | DHC | ES | PBS | IB |
| 1. Healthy Start interconceptional case management 3. Participate in Campaign to Prevent Teen Pregnancy 4. 2. | | X | | |
| 2. Teen Mothers Take Charge care coordination | | X | | |
| | | | | |

| | | | | |
|---|---|---|---|---|
| 3. Continue I'm Worth the Wait abstinence education | | X | | |
| 4. Surveillance - PRAMS | | | | X |
| 5. Distribution of condoms and birth control information | | X | | |
| 6. | | | | |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

b. Current Activities

The Healthy Start projects continue to work to maintain high risk women in case management for 2 years after birth to support their access to and utilization of health and other services, with family planning receiving major emphasis. Healthy Start staff receives periodic in-service continuing education on contraception, provided by Planned Parenthood and other providers. Healthy Start provides condoms and birth control information at 4 community office sites where outreach staff is stationed on a part-time basis. In addition to the incorporation of counseling concerning family planning services into case management and home visits, Healthy Start health educators offer informal education sessions on family planning at health clinics, housing developments and community centers.

1 Teen Mothers Take Charge contractor is continuing to provide services to 75 teen mothers. The Administration continues to operate PRAMS. The abstinence program continued.

See also NP# 9.

c. Plan for the Coming Year

Both Healthy Start projects were refunded and will continue to work to prevent unintended pregnancies through 2009. Teen Mothers Take Charge will continue with 1 contractor to serve 95 teens. The newborn initiative -- hospital based discharge planning (see other activities) will continue to incorporate information on family planning.

When the Healthy Start project obtains a replacement mobile site (expected October 2006), condoms, birth control information, and referrals to family planning services will be available curbside in target neighborhoods.

The Maternal and Child Health Officer and Healthy Start Director will use the information and knowledge obtained from the recent Preconception Health Care Summit hosted by the Centers for Disease Control to make presentations to staff and partners in anticipation of incorporating best practices for preconception health into the Administration's programs.

See also NP# 9.

State Performance Measure 8: *Percent of resident women who give birth with no prenatal care or entry into prenatal care in 3rd trimester*

| Tracking Performance Measures<br>*[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]* | | | | | |
|---|---|---|---|---|---|
| **Annual Objective and** | **2000** | **2001** | **2002** | **2003** | **2004** |

| Performance Data | | | | | |
|---|---|---|---|---|---|
| Annual Performance Objective | 7.6 | 7.1 | 6.6 | 6.2 | 5.8 |
| Annual Indicator | 8.3 | 7.5 | 8.3 | 7.3 | 7.3 |
| Numerator | 525 | 491 | 534 | 508 | |
| Denominator | 6356 | 6529 | 6469 | 6918 | |
| Is the Data Provisional or Final? | | | | Final | Provisional |
| | **2005** | **2006** | **2007** | **2008** | **2009** |
| Annual Performance Objective | 5.4 | 5.3 | 5 | 5 | 5 |

**Notes - 2002**

2001 is the most recent available data for the District. There is a two year lag time for vital records information. The denominator for 2001 excludes 1092 cases where the trimester of entry into prenatal care was missing/ unknown.

**Notes - 2003**

In 2003 there were 7, 6716 live births. The denominator does not include 698 with missing entry into prenatal care information.

**Notes - 2004**

2003 is the most recent available data.

## a. Last Year's Accomplishments

Focusing exclusively on the measurement of adequacy and early entry (SP#1 and NP# 18) may contribute to overlooking a significant number of women who deliver with no or very late care, women who are predicted to experience the most adverse birth outcomes. They are prime candidates for HIV counseling and testing, substance use treatment, and child abuse and neglect prevention, and require labor-intensive outreach, including curbside mobile services and home visits. This measure is related to several priorities: Increase the cultural competency of the MCH workforce and service organizations. Increase awareness of the role of mental health in adolescent risk behaviors, school achievement and perinatal outcomes; and increase availability of preventive services. Increase the proportion of the population that is insured, and increase the comprehensiveness of the coverage to include primary preventative services and preconceptional services.
Reduce unintended pregnancies and teen births. Timing of prenatal care is associated with NO# 1-6.

In 2003, 508 women, 7.3% of births for which information was recorded, entered prenatal care in the 3rd trimester or had no care. This proportion represents a change from 12% in 1996. The quality of birth record data also affects reporting on this performance measure: data on trimester of birth were missing on nearly 9% of resident birth records, an improvement over the 14% missing in the previous year.

Through July 2003, the mobile obstetrics unit, which provided curbside services on a rotating basis, was both a mechanism for advertising services and an intake site. The mobile unit was retired in August.

See activities described for SP# 1, 5 and NP# 15, 18.

**Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet**

| Activities | Pyramid Level of Service | | | |
|---|---|---|---|---|
| | DHC | ES | PBS | IB |
| 1. Healthy Start outreach and case management | | X | | |
| 2. HEALTHLINE -- information to callers | | X | | |
| 3. Transportation to uninsured women | | X | | |
| 4. Coordination of outreach with Medicaid MCOs | | | | X |
| 5. | | | | |
| 6. | | | | |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

## b. Current Activities

The 2 federally funded Healthy Start projects continue to work in low income African American neighborhoods. Healthy Start employees conduct community outreach and recruitment by door-to-door canvassing in neighborhoods and public housing communities, dissemination of flyers to patients and providers at community health centers, posting flyers and other materials at retail establishments such as hair and nail salons, laundries, supermarkets and corner stores, and contacting churches and community based organization. Outreach technicians also establish a presence at community events and meetings, and walk the commercial corridors in target areas. Information about services is published in community newsletters and media directed toward African American audiences. Staff participates in community health fairs supported by the DOH, as well as in street fairs and festivals sponsored by churches and neighborhood groups.

Another outreach strategy involves pregnancy testing and pregnancy registrations. Healthy Start staff, offer pregnancy testing at community sites and at health fairs and other special events. If the test is positive, the Healthy Start worker immediately assists the pregnant women in making a medical appointment, with her primary care provider if she has one, if not, at a community health center. The woman is assisted with completion of a pregnancy registration form. The Healthy Start worker encourages the woman to enroll in case management, and follows up within the next few weeks to encourage her to do so if she does not immediately enroll.

Pregnancy testing kits are being provided to the Addiction Prevention and Recovery Administration, Women's Services Center so that all women who present for substance abuse treatment can be tested. A position funded by the Administration serves as a liaison to ensure that pregnant women presenting for substance abuse services are enrolled in and case managed by Healthy Start.

## c. Plan for the Coming Year

Healthy Start will continue the efforts described above to find pregnant women and maintain them in prenatal care. The provision of family planning information and referrals to Healthy Start and Teen Moms Take Charge clients will continue.

State Performance Measure 9: *Incidence of repeat births for teens less than 19 years of age*

Tracking Performance Measures
*[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]*

| Annual Objective and Performance Data | 2000 | 2001 | 2002 | 2003 | 2004 |
|---|---|---|---|---|---|
| Annual Performance Objective | 20.9 | 20.6 | 20.3 | 19.9 | 19.6 |
| Annual Indicator | 18.5 | 18.4 | 16.4 | 16.1 | 16.1 |
| Numerator | 137 | 125 | 102 | 87 | |
| Denominator | 739 | 680 | 621 | 539 | |
| Is the Data Provisional or Final? | | | | Final | Provisional |
| | **2005** | **2006** | **2007** | **2008** | **2009** |
| Annual Performance Objective | 19.3 | 19 | 18.5 | 18.5 | 18.5 |

**Notes - 2002**

2001 is the most recent available data for the District. There is a two year lag time for vital records information.

**Notes - 2004**

2003 is the most recent year of data available.

## a. Last Year's Accomplishments

This state measure addresses the priority to reduce unintended pregnancies and teen births and is associated with NP# 8 and NO# 1, 2 and 6.

Beginning in 2001, the Administration received District TANF funds to develop the Teen Mothers Take Charge (TMTC) program. 5 community based service providers were funded through a competitive process to recruit 1st-time pregnant or parenting teens and enroll them in a program to provide intensive care coordination and supports, as well as enrichment programs. 700 clients were expected to be served with case management, social and employment services to be provided for up to 12 months after delivery or to a parenting teen up to the infant's 1st birthday. Interventions were intended to avoid repeat teen pregnancies and to maintain the clients in educational and/or work activities that fulfilled welfare to work requirements.

An evaluation of year 1 conducted by the University of the District of Columbia Center for Applied Research and Urban Policy found that 79% of the enrollment goal of 485 was met. As of May 2003, of the 466 women ever enrolled, 29% (n=136) had been discharged, including 8% (39/466) who were lost to follow-up or moved without a forwarding address. Another 8% were discharged due to noncompliance. Other reasons for discharge included transfer to another agency, infant death or miscarriage, and graduation. The discontinuation of 2 of the 5 vendors probably contributed to the discharges due to reasons other than completion of the program although efforts were made to transfer clients to other programs.

In FY 2003 after TANF support ended, Title V monies were applied to 3 grantees--Mary's Center for Maternal and Child Care, Shiloh Baptist Church Family Life Center and the Edward Mazique Parent Child Center. The services were changed to continue women in care coordination for up to 3 years. In FY 2004, 4 community based service organizations received grants; the 4th and new grantee was MELD/EvenStart, which provided care coordination to 50 African American teen mothers and their families. Grantees enrolled young women up to age 19 who had no more than 3 children. Care coordination was to have continued for up to 4 years or until the client was 19, whichever occurred first. In FY 2004 funding was reduced by approximately 20% and the number of women served was decreased accordingly. As of April 2004, 310 teens were receiving services (140 Shiloh, 50 Mary's Center, 70 Mazique and 50 MELD).

**Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet**

| Activities | Pyramid Level of Service | | | |
|---|---|---|---|---|
| | DHC | ES | PBS | IB |
| 1. Teen Mothers Take Charge care coordination, health education and enrichment | | X | | |
| 2. | | | | |
| 3. | | | | |
| 4. | | | | |
| 5. | | | | |
| 6. | | | | |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

b. Current Activities

In 2005, TANF funding was sufficient to support only 1 Teen Mothers Take Charge contractor, serving 75 teens and their families. The DOH requested appropriated funds as part of the FY 2006 budget submission, but the request was rejected.

c. Plan for the Coming Year

Teen Mothers Take Charge will continue as in FY 2005, with 1 contractor expected to serve 95 teen mothers. The newborn initiative -- hospital based discharge planning (see other activities) will continue to incorporate referrals to family planning.

## E. OTHER PROGRAM ACTIVITIES

DC Newborn Initiative (Discharge Planning)--
The Administration manages the Newborn Initiative through a cross-functional collaboration with other DOH programs, District government agencies, public/private entities and community partners. This Initiative is a major cornerstone of Mayor Anthony A. Williams' multifaceted citywide focus on strengthening children, youth, and families, reducing infant mortality and making government work in DC. The Initiative consists of an array of critical gap filling services that ensure the health outcome of women, newborns and their families. New mothers, parents and guardians are educated and given support on the physical, mental, and emotional care and well-being of newborns within the family

structure. While initial program activities identified in support of this integrated service intervention have received partial funding through the Federal Title V MCH Block grant, budgetary constraints within DOH indicate increasing difficulty in meeting continued funding obligations. Key components of the Initiative include but are not limited to enhanced hospital-based discharge planning services for all District newborns, ongoing case management as appropriate, and a nurse home visit within 72 hours of discharge from a hospital or birthing facility. Benefits to discharge planning include (1) solidifying a referral network between the Administration's HEALTHLINE and existing pre-natal and postpartum home visiting projects citywide; (2) connecting families in need to appropriate medical and community-based support services including referrals for new cribs, safe crib and SIDS education, newborns discharged from neonatal care, and other high-risk indicators such as substance positive infants; and (3) facilitating newborn assessment and home visit by a community health nurse to every newborn upon request of the parent. Assessments include home safety, childcare risks, nutrition, and a prenatal, medical and mental health history of the new mother. Families are also referred for other services on the basis of assessed need. The Administration provides a referral network between the HEALTHLINE and all existing District home visiting projects. These include Healthy Start (Wards 5-8), Mary's Center for Maternal and Child Health, Maternal and Family Health Nurse Case Management Program (Wards 1-4), Healthy Babies, Nurses for Newborns, and the Healthy Families, Thriving Communities Collaborative. HEALTHLINE operator's follow-up to determine if referrals were appropriately assigned within eight hours of a call. All families with newborns are eligible for this program and its services.

Epilepsy Initiative--
In 2004, the Administration received the federal grant, Awareness and Access to Care for Children and Youth with Epilepsy in the amount of $250,000.00 from September 1, 2004-August 31, 2007. The purpose of this initiative is to improve access to comprehensive, coordinated health care and related services for children and youth with epilepsy residing in MUAs. This initiative aims to establish links between families and MCOs while integrating community resources by employing family advocates at each of the four managed care organizations located in the District. DOH has successfully executed sub-grant agreements with three of the MCOs outlining specifications for the hiring and utilization of the family advocate. The MCOs include AmeriGroup, Chartered Health Plan, and HSCSHN, Inc. The mission is to ensure that each health plans' programs and services have input from caregivers and are responsive to the needs of this population. Caregivers will act as a member-advocate, seeking and coordinating creative solutions to members' health promoting care coordinated, ongoing and comprehensive systems to produce quality outcomes, and cost-effective and efficient utilization of all health services. Family advocates will be employed by the respective health plans with salaries subsidized by DOH. Year 1 funds have been utilized to support community partnerships to allow early detection and treatment by improving access to ongoing care, addressing shortages in subspecialty care, identifying cultural and language barriers, and developing strategies for improving current systems of treatment. DOH anticipates the demonstration project will improve access to comprehensive, coordinated health care and related services for children and youth with epilepsy residing in MUAs throughout the District.

Vision Screening
In cooperation with the Lions Club, Administration CSHCN staff has conducted for several years a vision-screening program, which offers a free screening for early detection of amblyopia in children from the ages of 1 to 6 years old. Due to the overwhelming demand, the Lions Club provided a full time project manager. In addition to the screening at child care and pre-school facilities, vision screening was also done at many of the District's middle and junior high schools. Lion's Club volunteers worked with parents to ensure that children who screened positive were seen for services and were provided with eye glasses. There are typically more requests from schools than can be met, in part because the program has better equipment than available at the school sites, and children are assured of being fitted with glasses. Many uninsured or underinsured children do not have access to being fitted with glasses.

## F. TECHNICAL ASSISTANCE

The Administration contracted with Health Policy Consultant Catherine Hess in both 2003 and 2005 to plan and facilitate the CAST 5 process. CAST- 5 tools were used in 2 phases. Some of the components of CAST- 5 were used in 2003 as part of a number of activities intended to strengthen the District's policy development capacities. Then in June 2005, the Administration utilized the remaining CAST- 5 assessment tools in the context of its comprehensive needs assessment. 18 persons, primarily senior managers, joined by some other key DOH representatives, participated during some part of the process, with 6 managers participating in both 2003 and 2005. Over the course of nearly 2 years, then, all of the assessment components of the CAST 5 process were completed. While CAST 5 also includes guidance for developing action plans based on capacity assessment results, management intends to follow-up on CAST 5 assessment results in the context of its overall planning.

Participants assigned the highest priority to: Access to timely program and population data from relevant public and private sources.

The realignment of the Administration and other components of the DOH described in sections of this application has generated discussion of at which organizational level to carry out public health surveillance, information management and program evaluation functions. Currently, each administration, including the Maternal and Family Health Administration, has staff positions dedicated to these functions. Recognizing that there may be compelling arguments for centralization, the Administration needs technical assistance to ensure that any centralization and/or warehousing results in the capability to generate and analyze data required for MCHB grant reporting. The Administration also needs to ensure the capacity to generate population based indicators of maternal and child health. The Administration management wishes to work with MCHB to outline a scope of work and identify potential consultants with the required experience.

The District has a high child-youth death rate (age 1-14 is 29, compared to 24) in the US. The Administration needs assistance from an MCH epidemiologist or health statistician experienced in working with mortality data to assist in the design of an analysis to identify trends in and contributing factors to mortality for the population aged 1 -- 21, by age group, gender and race/ethnicity.

## V. BUDGET NARRATIVE

### A. EXPENDITURES

Completion of Budget Forms: Please refer to forms 2, 3, 4, and 5 for a summary of how MCH funds were budgeted and expended.

Children With Special Health Care Needs: The expenditure for Children with Special Health Care Needs differs from the budgeted amount and is less than the required 30% because of a delay in the processing of the contract to provide medical services at two schools for Children With Special Health Care Needs. Although the services were rendered during fiscal year 2004 the payment for the services was not liquidated until after the close of the District's fiscal year and therefore the charges for these services will appear as part of FY2005 expenditures.

Administrative: The difference in the budgeted amount and the actual expenditure reflects a change in the method used by the Department in accessing actual administrative cost to programs and projects as well as re-categorization of charges from administrative to capital resulting in the cost being covered by the state.

Preventive and Primary Care: The State expended $2,448,860 or 34% of Title V funds on preventive and primary care services for children, such as sudden infant death syndrome counseling, immunizations and newborn screenings.

Budget

Maintenance of Effort: The District of Columbia exceeds the maintenance of effort requirements of Section 505 (a) (4). Washington continues to use the funding it expends to provide nursing services to all students attending public and charter schools within the District of Columbia.

The District of Columbia will continue to expend Title V funding to support the following efforts:

-Adolescent Health Initiative
-Community-Based Teen Pregnancy Prevention
-Genetics Program
-Newborn Metabolic Program
-Newborn Hearing Program
-Lead Poisoning Prevention Program
-Transportation Services
-Immunization Initiative
-Preventive Dentistry
-Health Education
-SIDS and Infant Death
-Pregnancy Risk Assessment Monitoring System
-Pregnancy Nutrition Surveillance System
-Oral Health Services
-Dental Sealant Initiative
-Infant and Child Mortality Review
-School-Based Health Centers
-Early Intervention Programs
-Breastfeeding
-Case Management and Care Coordination
-Medical Homes Initiative
-Men's Health Initiative
-Women's Health Initiative
-Sickle Cell Initiative
-Sudden Infant Death Syndrome (SIDS) Initiative
-Vision Screening

Other sources of Federal MCH dollars include:

-Eliminating Disparities in Perinatal Health
-Universal Newborn Hearing Screening
-Abstinence Education Grant
-District of Columbia State Systems Development
-Awareness and Access to Care for Children and Youths with Epilepsy
-Rape Prevention and Education
-State Grants for Perinatal Depression
-Genetic Services-Implementation
-Early Childhood Comprehensive Systems

Methodology: The State makes every effort to use the data collected by the Department of Health and other entities to direct MCH funds to address unmet needs. On a quarterly basis the Maternal and Family Health Administration proportions program expenditures to reflect percentage of effort in direct health care services, infrastructure-building, population-based services and enabling services. Program expenditures are also proportioned based on the "30-30-10" earmarking requirement of Title V.

## B. BUDGET

FY 2006 BUDGET

The increase in budgeted funds for Children 1 to 22 years reflects the Director's and City Council's emphasis on directing more of the Department of Health's funding on programs and projects that have a direct effect on improving the health of the citizens of the District of Columbia.

The increase in funding for Administrative Cost reflects the expected cost of reorganizing the Maternal and Family Health Administration with a focus on workforce analytics, and efficient award administration of sub-recipients.

EARMARKING REQUIREMENT

I. Preventive and Primary Care Services

The District of Columbia will continue to expend Title V funding earmarked for preventive and primary care on immunization, SIDS and infant death counseling, lead poisoning prevention, case management and care coordination, school-based wellness center, hearing screenings and genetic testing and counseling.

II. Services to Children with Special Health Care Needs

Title V funding is used to support the Children with Special Health Care Needs Division that provides programs and services mainly through sub-grants. These programs and services address newborn hearing and metabolic screening, genetic services, sickle cell and medical and dental services to students attending two District of Columbia schools specifically for children with special health care needs.

III. Administrative

Administrative costs in the Department of Health and the Maternal and Family Health Administration

include administrative overhead, internal accounting and information system charges, budgeting, and other charges generated from the operations and management units of the operating division.

IV. Maintenance of Effort

The District of Columbia will continue to provide the maintenance of effort (MOE) amount of $6,472,952. This amount is $1,094,112 in excess of the matching rate of $3 state dollars for every $4 federal dollars. The MOE funding provides nursing services to all students that attend public and charter schools within the District of Columbia.

## VI. REPORTING FORMS-GENERAL INFORMATION

Please refer to Forms 2-21, completed by the state as part of its online application.

## VII. PERFORMANCE AND OUTCOME MEASURE DETAIL SHEETS

For the National Performance Measures, detail sheets are provided as a part of the Guidance. States create one detail sheet for each state performance measure; to view these detail sheets please refer to Form 16 in the Forms section of the online application.

## VIII. GLOSSARY

A standard glossary is provided as a part of the Guidance; if the state has also provided a state-specific glossary, it will appear as an attachment to this section.

## IX. TECHNICAL NOTE

Please refer to Section IX of the Guidance.

## X. APPENDICES AND STATE SUPPORTING DOCUMENTS

### A. NEEDS ASSESSMENT

Please refer to Section II attachments, if provided.

### B. ALL REPORTING FORMS

Please refer to Forms 2-21 completed as part of the online application.

### C. ORGANIZATIONAL CHARTS AND ALL OTHER STATE SUPPORTING DOCUMENTS

Please refer to Section III, C "Organizational Structure".

### D. ANNUAL REPORT DATA

This requirement is fulfilled by the completion of the online narrative and forms; please refer to those sections.